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For September 1937

Just in Passing—

Cover Page—Adding to its architectural beauty are the fluted pilasters and sculptural details above the entrance to the Buffalo General Hospital, Buffalo, N.Y. Kidd and Kidd, Buffalo, were the architects.

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Hospital life in the city famous for its boardwalks is just one emergency after another, observes RAYMOND P. SLOAN, associate editor, after visiting the hospital there. Efficient organization enables the Atlantic City Hospital to give instant service, no matter how unusual the situation—a set-up that many persons attending the A. H. A. convention will want to observe first hand.

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Why not extend the services of your laboratory to take in all of this type of work in the vicinity, thus eliminating high overhead costs and promoting efficiency? asks H. R. FISHBACK, M.D., in the third of a series of articles on the hospital laboratory. Doctor Fishback is a member of the department of pathology at Northwestern University Medical School.

Those Subsidiary Workers 63
Qualifications, title and salary for this group have been worked out satisfactorily at the University of Colorado Hospitals, Denver. ERNESTINE BONG, R.N., assistant director of nursing service, tells how these things were done.

ONE month from date the thirty-ninth annual hospital convention will be history to the association but it will still be news to association members. The MODERN HOSPITAL for October will again present its convention report in tabloid newspaper form, with camera shots, candid and otherwise, and with interpretative, straight news and human interest stories on all that takes place. The Editors had so much fun and satisfaction out of reporting the convention last year that they have allotted additional space to this feature for October, 1937.

COVERING an A. H. A. convention is not simple. We know of no other gathering of similar importance and size that has not succumbed to the demands of the press for "hand-outs." Hand-outs are mimeographed abstracts of important papers and other official releases regarding special program features. Reporters on local papers and correspondents for national press services nowadays are either so independent or indolent, according to one's point of view, that they do not give a convention much of a play in the newspapers or news weeklies unless the association's publicity person has this material ready and waiting for them. Reporters cannot cover, single-handed, three or four meetings at once and won't attempt it. The MODERN HOSPITAL tries to do this, and you will see next month how well it has succeeded.

IN THIS issue, the convention lends color to a great many pages. The associate editor went to Atlantic City and spent a day in the hospital there—as a visitor, not as a patient. Beginning on page 46 is an

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account of that little journey; you'll miss something if you pass it by. Once you have read Mr. Sloan's article, you will want to dash around to the Atlantic City Hospital where even emergencies have become a routine.

INSTEAD of publishing the complete convention program, which the official association journal now does, we have departed from custom and, on page 51, we take you to the dress rehearsal of the dramatizations and demonstrations that will enliven this year's convention.

These clinical demonstrations and dramatic skits are the pleasantest sort of relief from hour upon hour of unalloyed speech-making, and the association is to be congratulated on the live turn its programs are now taking. Entertainment and instruction go hand in hand.

ON PAGE 90 enter, Alice-in-Wonderland fashion, if you will, some of the miniature rooms that will attract all delegates to the booth of the National Executive Housekeepers Association. These energetic women are fast emerging into prominence in hospital gatherings as they are in hospital management.

BEGINNING on page 104 the news section has convention stories and programs on almost every page. In fact, it looks as if Atlantic City is going to be considerably more like a beehive than like a playground about mid-September.

MRS. TONG Y. CHIN is the wife of a Cleveland merchant and a fairly recent arrival from China. Her husband told her that she must have her baby in a hospital. He also told her that a man physician would deliver the child. Then she knew that she would never live to see her husband's dear face again. But she promised to obey him as every good Chinese wife must learn to do. While she prayed that her baby would be a boy and that it would live for seven days (for, in China, if a baby lives seven days it lives all its days) she also prayed that she would not have to enter that terrifying hospital.

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Her prayers were only one-third answered, but her maternity experiences in a Cleveland hospital were happy ones and, safe home with her new daughter, she will tell her opinion of American hospitals in the next issue.

DR. NORBERT ENZER of Mount Sinai Hospital, Milwaukee, has the idea that the only satisfactory way for a small hospital to provide a useful laboratory service is through the medium of an "insurance laboratory plan." He will describe this plan in the next issue.

THE set-up and cost of a physical therapy department are subjects of a worth while article by Helen L. Kaiser, chief physical therapy technician of Mount Sinai Hospital, Cleveland. This manuscript, with attractive illustrations, is scheduled for publication in October.

FLASHES FROM THIS ISSUE:

"Anyone inclined to study specialized service in hospital management at first hand would do well to spend some time at Atlantic City Hospital. The set-up is based on the assumption that no one receives new for old until she first returns the old." *Page 50.*

"The hospital cannot conduct its pay or private service on a special (less than cost) rate for a privileged group without dipping into its trust funds, unless it raises the rates to the other nonprivileged classes." *Page 54.*

"There is no hospital better suited for study of the value of reading than a hospital for the mentally ill." *Page 74.*

"Hospital directors should insist that they be given a voice in the organization of public health programs, such as the control of syphilis, in which the hospital holds a position of great importance." *Page 44.*

"The executive housekeeper should encourage her employees to bring in suggestions for the good of the institution. . . . Many times a situation is saved because some employee in a minor position kept his eyes and ears open and did his talking to the department head." *Page 86.*

"Elaborate mechanism is sometimes purchased for a task that skillfully planned buzzers and annunciators could accomplish." *Page 82.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.

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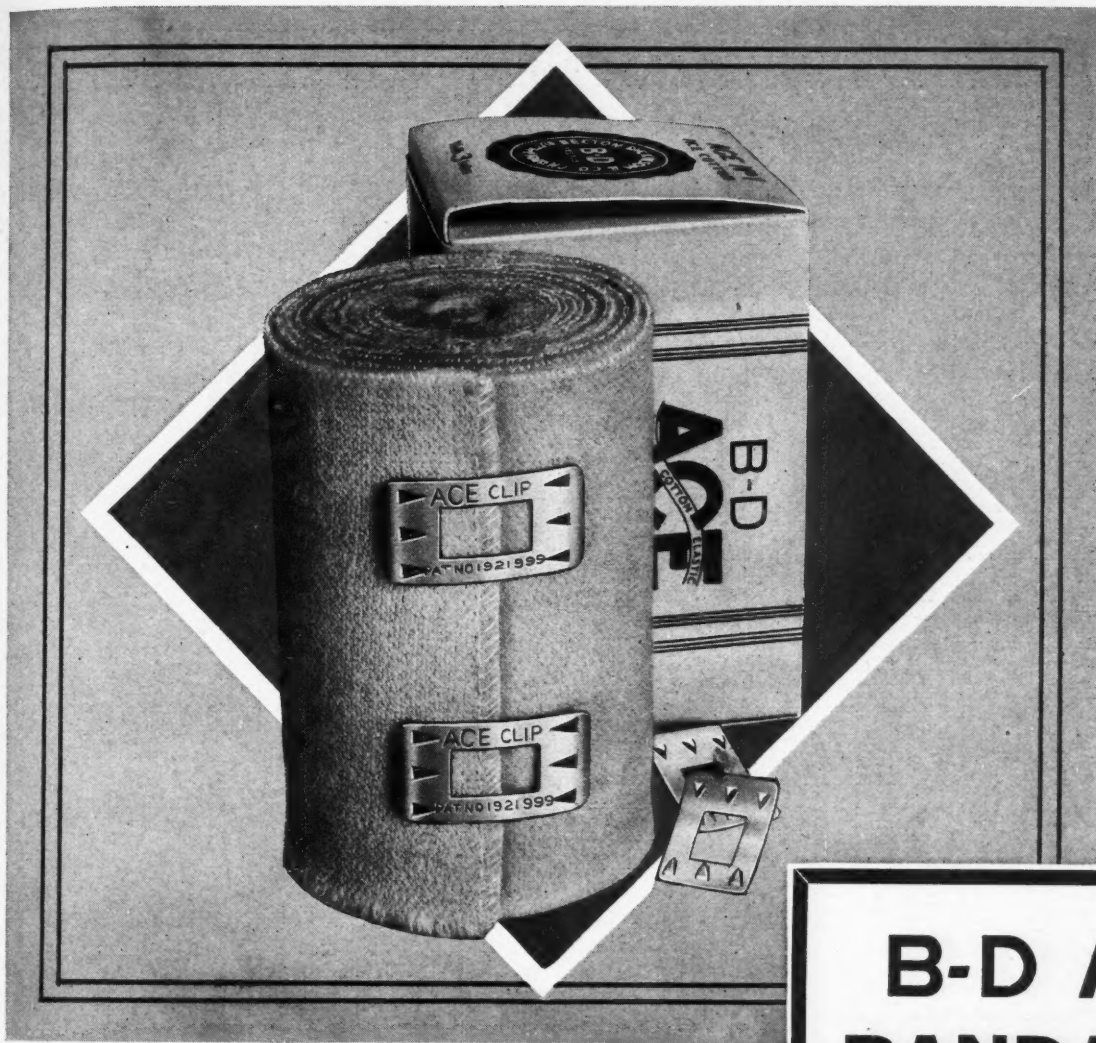
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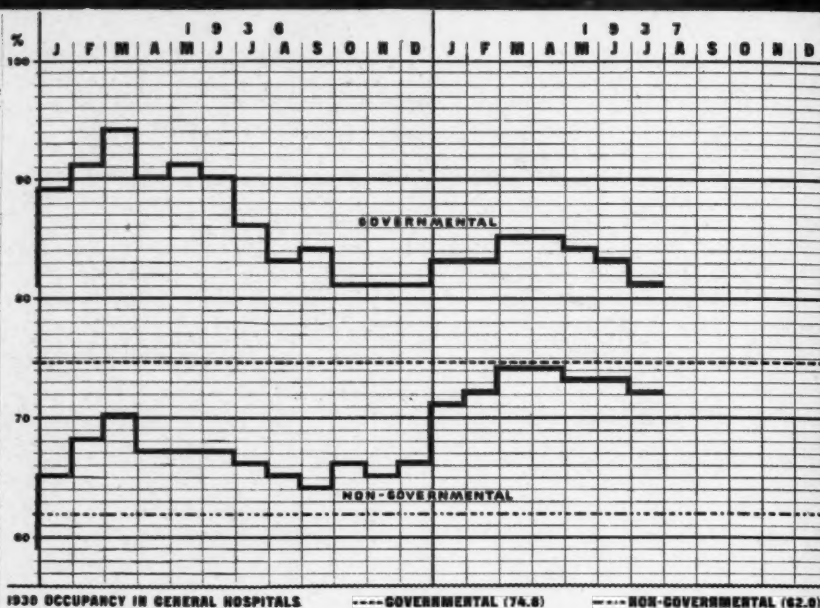
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HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data, on Reporting Hospitals ¹		1937		1936	
	Hosp	Beds ²	July	June	July	June
Government						
New York City.....	17	11,328	88	99*	87	90
New Jersey.....	5	2,122	80*	89*	79	82
Washington D. C.....	2	1,596	70*	70*	65	65
N. and S. Carolina.....	13	1,519	70	72	72	75
New Orleans.....	2	2,466	98	98	148	168
San Francisco.....	3	2,255	85*	85	88	80
St. Paul.....	1	850	62	69	70	78
Chicago.....	1	3,419	84*	84	81	83
Total ⁴	44	25,555	81*	83*	86	90
Nongovernment						
New York City ³	68	15,194	81*	81*	69	73
New Jersey.....	50	9,772	71*	71*	63	64
Washington, D. C.....	9	1,793	77*	77*	72	73
N. and S. Carolina.....	107	6,682	68	69	69	67
New Orleans.....	7	1,146	73	69	64	63
San Francisco.....	15	3,129	75*	75	73	73
St. Paul.....	8	884	68	73	56	59
Chicago.....	12	2,424	62	66	59	64
Cleveland.....	15	2,855	75*	75	69	68
Total ⁴	291	43,879	72*	73*	66	67

^aExcluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. ^bIncluding bassinets, usually. ^cGeneral hospitals only. ^dOccupancy totals are unweighted averages. ^ePreliminary report. Complete occupancy figures for January, 1935, to October, 1936, are given on page 800 of the Fifteenth Hospital Yearbook.



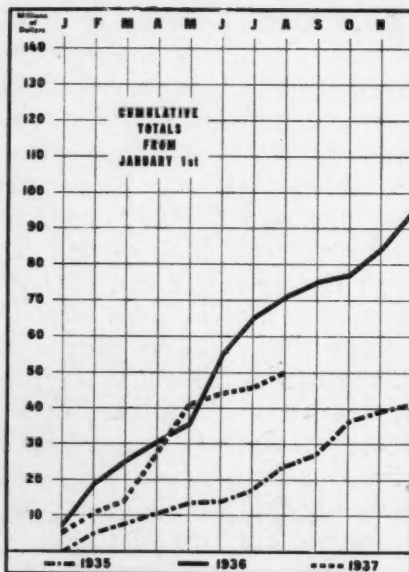
Bed Occupancy Slumps Slightly During Summer Heat

Following the seasonal trend—a trend that will be reversed when air conditioning becomes more prevalent—occupancy in both government and nongovernment hospitals took a slight drop during July, the average decline in government hospitals being two points, from 83 to 81 per cent, and in nongovernment hospitals one point, 73 to 72. The most notable changes in occupancy were shown by nongovernment hospitals in St. Paul, which abruptly dropped off from 66 to 62 per cent, and the nongovernment group in New Orleans in which occupancy climbed an equal number of points, from 69 to 73.

Hospital construction gained a little headway in July with a total of thirty-one new projects of which twenty-eight reported an expenditure of \$3,278,673. As has been the case for so long, new additions accounted for most of the money to be spent. Out of the thirty-one projects, twenty-five were new additions, with a cost of \$1,258,673. Alterations and nurses' homes remained in the doldrums with only one of each reported for this period. The nurses' home is to cost \$65,000; the alteration, \$35,000. Four new hospitals will cost \$920,000.

General prices as reported by the *New York Journal of Commerce* re-

HOSPITAL CONSTRUCTION

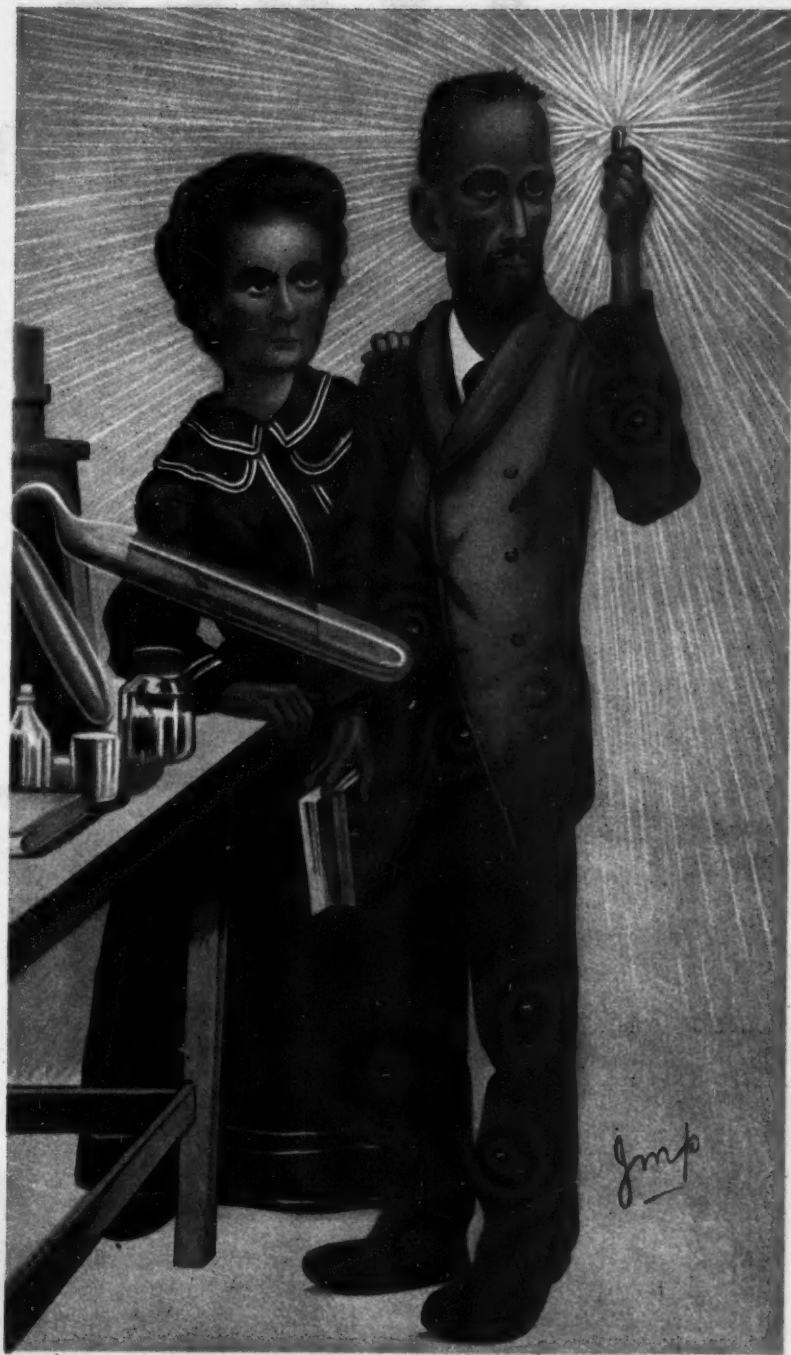


mained fairly steady—between 90 and 91. The highest point reached in the four weeks from July 17 to August 16 was 91.5 the week of August 2; the lowest, 90, reported on August 16. Grain prices have performed some remarkable gyrations from week to

week. From 114.8 on July 17 they have dropped to 95.2 on August 16.

Food costs have also been jumpy. A fairly sharp rise occurred the first two weeks of the period, from 84.1 to 89.2, the highest point reached for a long time. The last two weeks, however, showed a decrease to 86.2. Prices of textiles have declined steadily, falling off to 69.7, while fuel has remained practically stationary at 89.1. Building materials also fell off, dropping to 100.2. (All indexes based on 1927-29 as 100). The *Oil, Paint and Drug Reporter's* price index remained at 181.5 for drugs and fine chemicals for the first three weeks of the period reported and then lost a tenth of a point, closing at 181.4.

The U. S. Bureau of Labor Statistics, reporting the retail costs of food, states that the average cost of foods declined 0.4 per cent during the month ending July 13. The food cost index for July 13 was 85.9 per cent of the 1923-25 average. It was 2.2 per cent higher than for the corresponding period of a year ago, but 19.4 per cent below the level of July, 1929, when the index stood at 106.5. Indexes for all major commodity groups except fruits and vegetables are now higher than a year ago, with meats showing the greatest advance.



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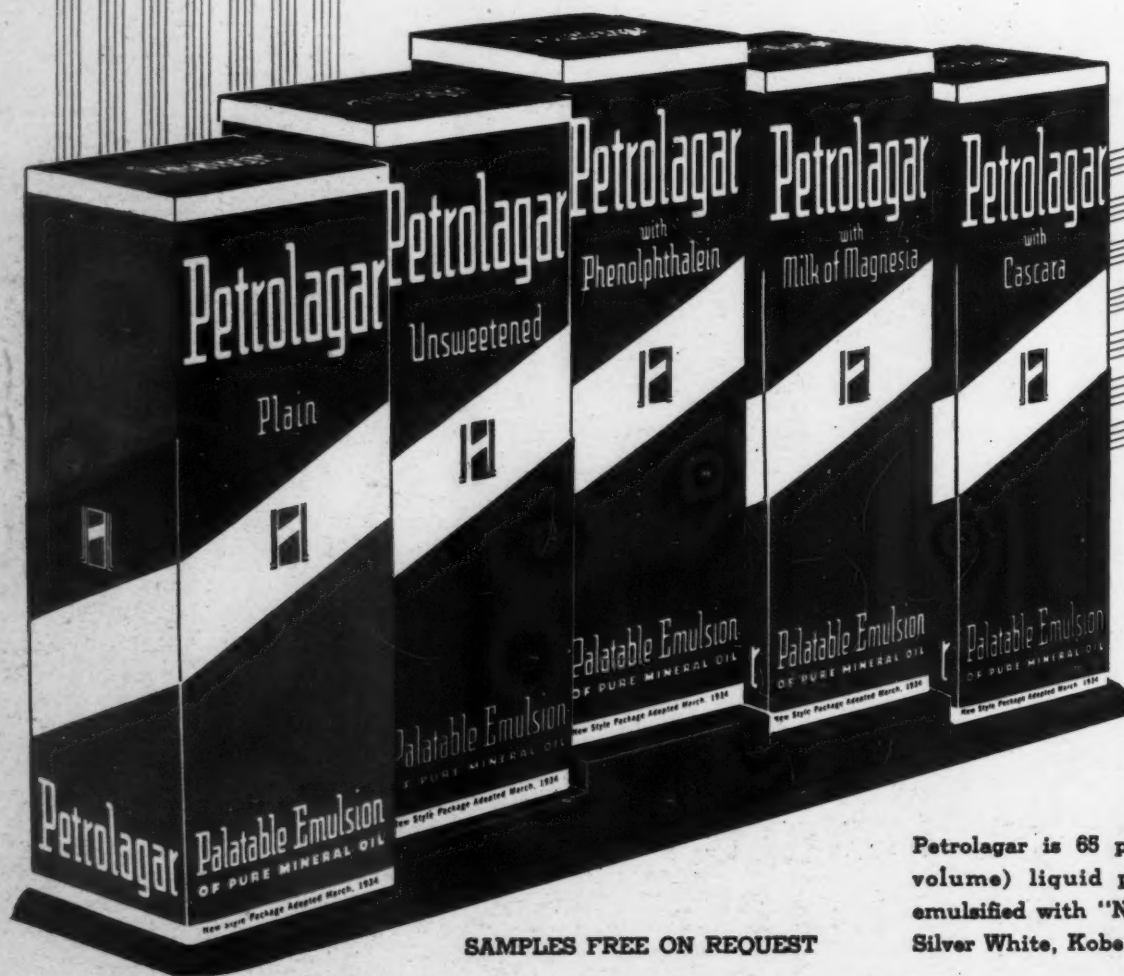
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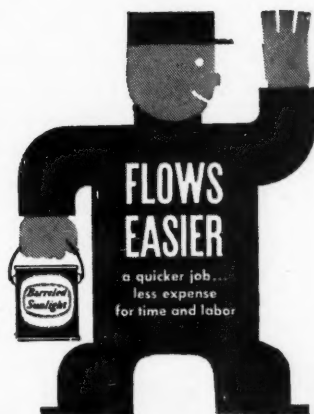
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The Editor Talks It Over

Backstairs Gossip

• Nothing is more pernicious than hospital gossip. There are few institutions in which this objectionable practice is not found to some degree. There is truth, moreover, in the statement of a well-known humorist that he could never understand the justification of the term "private hospital," since in most instances hospitals are as private as Forty-Second Street at Fifth Avenue.

Talking too much concerning the affairs of others and the medical happenings of the hospital day is a practice as difficult to control as a malignant disease. The remedy is equally elusive.

Recently one member of a hospital board recommended abolition of the intern and staff dining room because it was a favorite pastime to gossip there about the hospital's patients. The number of gall stones removed at an operation, the visible panic of the preoperative patient, the doings in the maternity and the latest news concerning the current institutional love affair all are dainty morsels to be rolled beneath the tongue of the careless.

It has been observed that patients are likely to shun gossiping institutions because, while there, everybody knows everything about them. The goings and comings of private patients through a main admission hall often lead to embarrassing situations. Because of this, those who plan hospitals often set aside a separate entrance for private patients. There is no known cure for the institutional gossip. The only possible remedy is his complete extermination.

Help Takes a Holiday

• Do you give orderlies, porters and floor scrubbers a vacation during the hot summer months? Or do your vacation policies apply only to in-

dividuals and not to classes? One should not suppose that long hot hours spent in kitchens are not fatiguing, or that scrubbing floors is not an occupation productive of a high degree of ennui. One executive remarked that vacations were not given to those in the lower economic brackets because they never had been requested. Such an excuse for neglecting the welfare of the members of the hospital's personnel is absurd. Vacations of some length for all having worked at least a twelve-month represent an act of justice as well as a highly profitable practice. Some hospitals sponsor an annual picnic. At one institution temporary telephone lines were run to the dining table on the hospital lawn that doctors and department heads might be summoned. Some hospitals offer a night at a near-by moving picture house and others a more elaborate entertainment such as a boat ride or a picnic at a pleasure park. All of these bolster morale.

Good Food, Good Temper

• Bronson Alcott was a vegetarian. His conversation with Carlyle about the effect of certain foods is a classic. "People," said Alcott, "are like what they eat. For example, he who lives on pork becomes hoggish, on beef ox-like and on mutton sheep-like." "Yes," said Carlyle, "but don't you think, Mr. Alcott, that if a man lives altogether on vegetables he is in danger of becoming pretty small potatoes?" Witty, but suggestive in its application to the hospital. Good food begets good tempers and encourages patients and personnel to become good publicity agents for the hospitals. Bad food produces sour, complaining and undisciplined patients and personnel. A good dietitian is one of the best publicity directors as well as one of the most effective disciplinarians the hospital can well possess.

Check on Orange Juice

• What becomes of all the orange juice these torrid summer days? There is the faintest suspicion that it is not only the patients who are refreshed thereby. A careful checking of requisitions for liquid nourishments is a remedy for checking non-patient use of orange juice. When this is not done, with citrus fruit soaring in price, dietitians surely will age prematurely in endeavoring to keep down per capita food costs.

Irish Indignation

• A large general hospital in the East is known locally as "Blockley," because many years ago the township in which it had its beginning was so called.

A former female resident of the Emerald Isle recently honored its receiving ward by her presence in search of relief for a varicose ulcer on the lower extremity. When it was explained by the nurse that the outpatient department and not a snug hospital bed would be a suitable place for her treatment, and when this opinion was substantiated by the intern on duty, the patient indignantly replied: "I will not be 'sassed' by no snip of a 'white cap' nor no 'kid' doctor neither. 'Mr. Blockley' gave this hospital for such as me, and I demand me rights."

Guests at Table

• How have you solved the problem of controlling visitors to staff and nurses' dining rooms? Some hospitals sell meal tickets to nonresidents who desire meals at the hospital. It is common belief that furnishing meals to staff physicians is not a sound or necessary practice. Regardless of the plan that is adopted, a lack of policy on this matter will add measurably to the hospital's mounting food costs.

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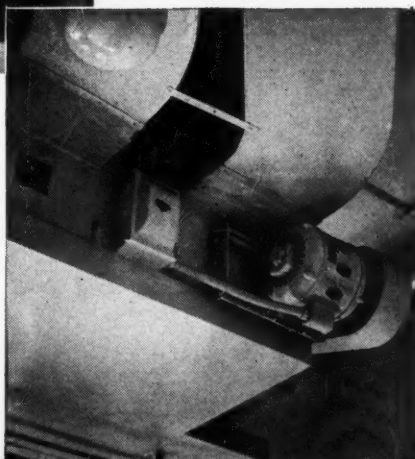
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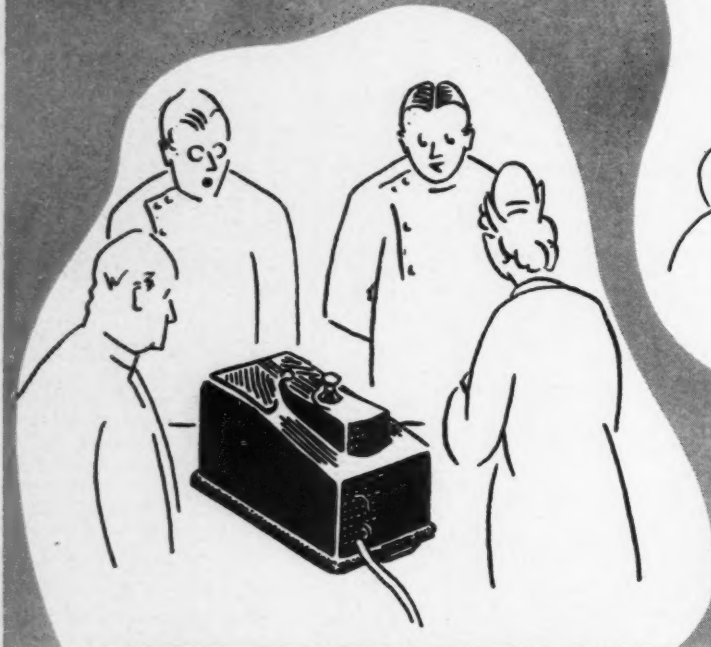
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Looking Forward

Challenge to Administrators

How much of the lack of personal interest displayed by many trustees in hospital affairs may be attributed to inadequate guidance on the part of the administrator? In lamenting the absence of support his governing body renders him is not the superintendent admitting his own shortcomings?

He is a poor man indeed who cannot find within hospital walls some interests, no matter in what direction his tastes may lie. But he must be initiated and guided, that he may find some measure of happiness from his association and that the institution may actually benefit by his intelligent participation in its affairs.

Why not plan a definite program for the education of hospital trustees that will carry through this fall and winter—a comprehensive study of present day hospital problems, if you please, based not wholly upon the institution's needs but on the community's health program. Surely such action will go far in assuring the future of the voluntary hospital. A broader perspective on health and a more intimate acquaintance with hospital service are requisites of modern stewardship, constituting a challenge the far-sighted and thoughtful administrator will not refuse.

Senator Lewis Proposes

THE height of medical regimentation was reached on July 28, when Senator James Hamilton Lewis of Illinois proposed by resolution to make in effect all licensed medical practitioners officers of the federal government.

This plan like many others of its general intention is clothed in the beneficent vesture of the Good Samaritan. Its aim, it is said, is to provide medical aid for the needy when stricken with disease. Not only would doctors be affected by this proposed legislation but hospitals also would be in a measure under federal control.

All physicians enrolled with or without their consent in a civilian medical corps would be forced under penalty to answer any request for treatment from any indigent person. Such a physician could order hospitalization in any institution. If the hospital should charge too much it would be punished. If the doctor should overcharge he would be fined or imprisoned. Who is to judge as to the worth of the service rendered or as to the justice of the fee is yet to be determined. Supposedly an appointed board would be in a measure under federal control.

Voluntary hospitals want to live their own lives. They do not fancy regimentation. Doctors do not desire to be forced to practice medicine in a fashion determined by some federal committee or board.

The plan would complicate an already difficult medical and institutional situation. It is the panel system of the Old World with 1937 American adaptations.

Apprenticeship in Administration

IN THE course of the day's news comes a letter from the new superintendent of Toledo Hospital, W. L. Benfer. "I started my hospital career," Mr. Benfer reminisces, "as a clerk in the storeroom of this hospital in 1928. From this position I became bookkeeper, later secretary to the superintendent, and in 1931 I was appointed auditor, which position I held until January of this year. At that time I was appointed acting superintendent following the death of George W. Wilson."

This is the simple story of a man of ability in the ranks who, under the guidance of a competent administrator, gradually learns hospital administration through observation and first-hand participation. To other hospital employees of ability it should offer encouragement.

But there is a new idea in hospital administration to which those aspiring to administrative

posts also should give heed. It was put in concrete form at the last convention of the Catholic Hospital Association. A resolution adopted by this body declared its support for the A. C. H. A. program for the training of hospital administrators. In presenting the resolution, Father Schwitalla specifically stated that it looked in the direction of a master's degree in hospital administration as the minimum requirement—not this year or next year, but within the next ten or fifteen years.

Apprenticeship always will play a large part in the education of hospital administrators. Those who have a master's degree in the subject or have taken formal work of university rank will find that classroom work needs to be supplemented by the practical experience gained under the tutelage of a competent administrator.

But academic training without actual experience is probably no less complete than experience without the broadening influence of the lecture, the seminar and the reading and discussion of hospital literature. Both are necessary and, increasingly in the future, both will be offered by leading applicants for hospital positions.

Who Should Worry?

A DISTINGUISHED physician of New York City, now well along in the seventh decade of life, enjoys telling his young medical friends how in his early hospital days the insertion of a clinical thermometer into the mouth of a patient was strictly the prerogative of the physician, the performance of such a procedure by a nurse being then regarded as highly unethical. That was fifty years ago. Events move faster nowadays. Ten years hence, what will the verdict of history be on the action of the House of Delegates of the American Medical Association last June, when it attempted to set up a barrier between "medical" and "hospital" services and laid down the law to group hospitalization plans?

"... the contract benefit provided by group hospitalization insurance should be limited to the room, bed, board and nursing facilities ordinarily provided by hospitals and routine medicines. In regard to certain benefits offered by many hospital insurance plans, combining professional and technical services, the committee is in complete sympathy with those who would make every possible provision to prevent inclusion of any types of services involving medical care."

Is it the prerogative of the medical profession to decide on hospital policies all by itself? The

modern hospital may be defined as a partnership between a public or semipublic body that is responsible for the hospital, and the physicians who work in the institution. The actual and potential patients of hospitals are a third party in interest. Should the trustees of hospitals included in reputable nonprofit group hospitalization plans be told what they must and must not do? Can the three-quarter million members of group hospitalization plans be ignored? As a practical matter, well-organized group hospitalization plans that have already included x-ray, anesthesia and laboratory services, with the cooperation of their local medical societies, are likely to go ahead as they have been going.

Is it seriously proposed that hospital anesthesiologists, roentgenologists and pathologists may no longer furnish services in a hospital except on a fee basis like visiting surgeons? Or is this principle to be applied only to the care of patients who come in under group hospitalization plans? If the general principle as laid down by the House of Delegates is sound, what is the logic of applying it to group hospitalization only? And if it is to be applied to all anesthesia, x-ray and laboratory services for all patients, why, then the hospitals are in for a considerable revamping of their professional, administrative and financial organizations, that is, they are in for a reorganization insofar as they decide to reorganize.

Group hospitalization authorities, hospital officials and trustees, physicians in general and the American Medical Association officials in particular shouldn't lie awake nights. If they all think about this seriously and quietly in the daytime, they won't need to.

Economic Creed of the Patient

IT IS rare for a patient or his relatives to remark to the hospital executive that the institution's price card is reasonable and that the patient received his money's worth. It is much more common for the patient, upon learning the rate set by the hospital, to ask for a reduction.

Such a state of mind is as ridiculous oft-times as it is baffling. A prospective hotel guest would never attempt after inspecting a high priced and a low priced room to obtain the former at the rate of the latter. The hospital patient, however, feels no embarrassment in requesting a reduction of his fee or even a total franking of the items on the hospital rate card.

The honest merchant who fixes a price on his wares adopts the attitude that the purchaser may secure the article by paying the price or

may leave the store empty handed. The hospital executive often is afraid or unwilling to allow possible customers to go away without being served. He shrinks from leaving an impression that the dollar sign is of importance. To be sure, generosity gave birth to the hospital. The public, however, apparently expects the hospital quickly to give back the money in the form of free service. It is not out of place for a hospital executive, having presented a rate card, to insist firmly but courteously that there can be no reduction from these prices.

To give favors to one and not to another is unethical. The difficulty is that hospitals in a community possess no common policy and that some of them encourage bargaining. The public will never be reeducated on this matter until more institutions adopt the attitude of offering a service that will fit each purse and, having done so, refuse all requests for reductions.

The Time of the Millennium

WHEN the millennium comes we are promised that all will be well and that injustice, ignorance and incompetence will be forever banished. Certain matters which concern hospitals probably must wait for correction until this time arrives.

Then no hospital will assert its supposed superiority over any other. None will figuratively spend sleepless nights planning a financial coup to put to confusion its neighbor. Rate cards will be planned on the basis of community needs rather than on a price war plan. The multiplication of costly laundries, x-ray and power plants will be discouraged and group effort substituted as a means of economy. Hospitals but a few blocks or even miles apart will not own and maintain expensive fleets of ambulances but will requisition such a service from a common garage cooperatively owned and maintained. When the institutional millennium comes boards of trustees will be willing to close or merge hospital plants that are expensive to maintain or unnecessary from the standpoint of community needs. Then and only then it is feared will the efficiency and economy evident in business activities be practiced in the hospital.

Why wait for the arrival of a future time of perfection, one may ask. Lack of community vision, an attitude of self-superiority charitably denominated as a desire for autonomy, the existence of a small business competitive spirit—these and many other reasons seemingly without remedy take heavy toll in the efficiency

and economy of hospitals. Moreover, neither moralizing nor pleading, neither statistical proof nor common business sense has as yet made more than scant progress in solving these problems. When the millennium comes—!

Character of the Staff

SHALL the major staff consist of a group of specialists who are chosen because they are ranking consultants or shall the general practitioner be generously represented thereon? Beyond question a full-time highly specialized staff is capable of rendering a distinguished service to any type of hospital. To many this is a highly desirable but wholly impossible arrangement. To recompense such a full-time group would require a sum entirely beyond the resources of all but the most heavily endowed institutions. There are some, however, who believe that a practicing visiting staff is desirable.

Some hospitals have elected distinguished physicians and surgeons to head their various staffs limiting sharply the granting of courtesy privileges to others. Such an arrangement which approaches the closed hospital principle has seldom served to attract a large volume of patronage.

It is probably a wiser practice to arrange for privileges for community physicians by integrating them into a staff as assistants on ward or dispensary, thus extending to them the educational and ward facilities. A certain loyalty to the community's institution will thus be generated which will be reflected in increased private room and ward patronage. The community doctor will remain as the backbone of the hospital.

Hunches

A HUNCH is the colloquial term for an unsupported belief or conjecture as to a probable occurrence or an outcome from some course of action. An individual has a hunch to do or not to do. A hospital administrator instinctively feels that a certain apparently harmless combination of circumstances possesses inherent factors of danger for the patient. A new employee for reasons not tangible appears honest or dishonest. Accidents come in series of threes and patients who prognosticate their own deaths often succumb to an operation. "Superstition!" shouts the matter-of-fact. Mere guesses plus a certain modicum of coincidence conclude others. Maybe so, but hunches are often worthy of following in hospitals as well as in horse races.

Service to the Syphilitic

WHEN the patient with tuberculosis goes to a hospital, he goes to stay for a long time. His treatment is an extended one. He will be contagious until arrest is attained.

When a patient with smallpox, typhoid fever or poliomyelitis enters a hospital, he is an acute problem of infection for a short period. As an in-patient he belongs in the isolation ward.

Syphilis is a different problem. Save in rare cases there is no need for in-patient treatment. Treatment may be given which renders the patient noninfectious almost immediately and he remains only during the actual time required for the administration of treatment. Between visits to the out-patient department the syphilitic patient is at work, living a relatively normal life. Because syphilis presents a different yet easier problem many hospital staffs have not fully appreciated the great assistance they can render the community through effective cooperation with health departments in syphilis control.

Every syphilologist and well informed health officer appreciates the need for making provisions within the hospital for facilities for diagnosis and treatment of patients infected with syphilis. The requirement that a routine serologic test for syphilis be done on every person admitted to a hospital would yield greater returns in the prevention of human misery than any other single measure of comparable simplicity. Nor should the importance of the darkfield examination for the detection of the *Spirochaeta pallida* be forgotten.

Hospital's Three Duties

Once the diagnosis is established the hospital staff is required to provide treatment. Most syphilis patients are unable to pay the regular fees of a private physician for a prolonged course of treatment even though they remain at their regular work. The hospital, therefore, is confronted with the problem of providing care for a large number of medically indigent patients. To fill needs efficiently service must be provided for:

1. The diagnosis and emergency treatment of any patient who applies.

2. Any patient with syphilis who is referred by a private physician either for continuous treatment or for consultative advice and opinion.

3. Any patient who is unable to afford private medical care.

In the past considerable sums have been made available to hospitals by unofficial and voluntary agencies. The neglect of the syphilis patient in many institutions in the past and the poorly organized clinics in many hospitals point to a grave need for supplementing voluntary funds. Funds should be made available to the health department for extending direct subsidies to hospitals that conduct efficiently operated clinics and render other valuable service.

Hospital directors should insist that they be given a voice in the organization of public health programs, such as the control of syphilis, in which the hospital holds a position of great importance.

Privacy for Patients

It is in the out-patient clinic that syphilis control work is conducted on such a large scale. The polyclinic holds a position of much advantage in serving syphilis patients. Its performance cannot be equaled by a syphilis clinic detached from a hospital unless the latter is conducted in a way many times more efficient than is customary. The polyclinic protects the identity of the patient and does not disclose to the public the fact that he is infected with syphilis. It provides special consultation service with the manifold specialties related to syphilology. When located in a hospital the polyclinic may be closely coordinated with the in-patient activities in such way as to ensure the immediate provision of in-patient treatment in the cases in which this is indicated.

Within the syphilis section of the polyclinic, privacy for the patient is essential when the examination is conducted or when treatment is administered, and a reasonable degree of privacy in the waiting room adds much to the attendance at the clinic. Especially to be avoided are long and unnecessary periods of waiting for the administration of routine treatment not only because this is unpleasant and vexatious to the patient but also because it may add to his economic embarrassment and interfere seriously with his ability to hold a job. Both day and night clinics are essential to prevent loss of time from work and to assist the patient to maintain employment.

By R. A. VONDERLEHR, M.D.

Patients who have not attained the age of puberty, if they are to be treated in the regular syphilis clinic, should be cared for during hours when adult patients are not admitted. Saturday mornings are an ideal time.

The pregnant woman coming for prenatal care, if infected with syphilis, also should be given treatment either in the regular prenatal clinic, or if this is impossible, in the syphilis clinic at a time when other adult patients are not treated.

Right Type of Doctors

Physicians serving in the syphilis clinic should be thoroughly qualified as physicians and proficient in the specialty to which they limit their work. They should be tactful and sympathetic. They should be paid fair monetary compensation for services rendered and the clinic chief should insist upon their regular attendance during the entire clinic session.

The medical social service is second in importance only to treatment. No clinic can give effective treatment without a well trained staff capable of performing the intricate duties connected with case finding and case holding. All medical follow-up workers should be full-time employees especially trained in this work.

Standardization of syphilis treatment insofar as it is practicable is highly desirable. The findings of the committee on syphilis and cognate subjects of the medical organization of the League of Nations and the work of the Cooperative Clinical Group in the United States on studies of the treatment of syphilis indicate that the continuous alternating method of therapy now advocated by the Public Health Service is the most effective scheme of treatment in early syphilis.

To ensure the completion of adequate standard treatment a system of keeping records should be adapted to such schemes and particular attention paid to the transient, transferred and incompletely treated patient. To patients coming within the latter categories the original clinic should give a statement or a record of the treatment that has been received as a factor in promoting the continuity of therapy. An inter-clinic system of comparative notification aids thorough treatment.

The hospital should be prepared to receive patients with syphilis who, because of some serious complication or because of some untoward result developing during the course of treatment, require in-patient service. Not only should in-patient treatment be made available for those who have been rendered service in the polyclinic of the hospital but hospital authorities should cooperate with separate clinics.

An effective and well developed program against syphilis implies much more than the routine administration of treatment to the patient with early and latent syphilis and to the syphilitic expectant mother. It contemplates the reasonable provision of complex diagnostic laboratory services which can be rendered by a well equipped hospital only. Studies of the spinal fluid, roentgenologic examinations of the cardiovascular stripe and long bones, and other special laboratory facilities should be available.

Provision of this service is not only an obligation of the health department but a peculiar responsibility of the department of public welfare since individuals with asymptomatic central nervous system syphilis and incipient cardiovascular disease are potential candidates for the mental or general hospital a few years later. A half dozen hospitals equipped to do this special diagnostic laboratory work easily might serve the average state if provisions were made for the transportation of indigent patients.

Big Chance for Hospitals

It is my contention that the hospitals of the country have no greater opportunity to assist in the control and prevention of disease, to promote the welfare of the people and to provide for the efficient care of the sick—all of which are aims of the American Hospital Association—than they have in rendering service to the syphilitic patient. The health department is an agency interested in all of the aims and purposes of the American Hospital Association that have to do with the control and prevention of communicable disease.

These two agencies should work vigorously in the attainment of the following goals: (1) nationwide adoption of the routine serologic test for syphilis in all institutions; (2) administration of treatment for syphilis to all patients who are medically indigent; (3) provision of humane care for all syphilitic persons requiring hospital in-patient treatment; (4) development of efficiently operated syphilis sections in polyclinics, and (5) adoption of standard methods for diagnosis and treatment insofar as present knowledge permits.



A Day in Atlantic City

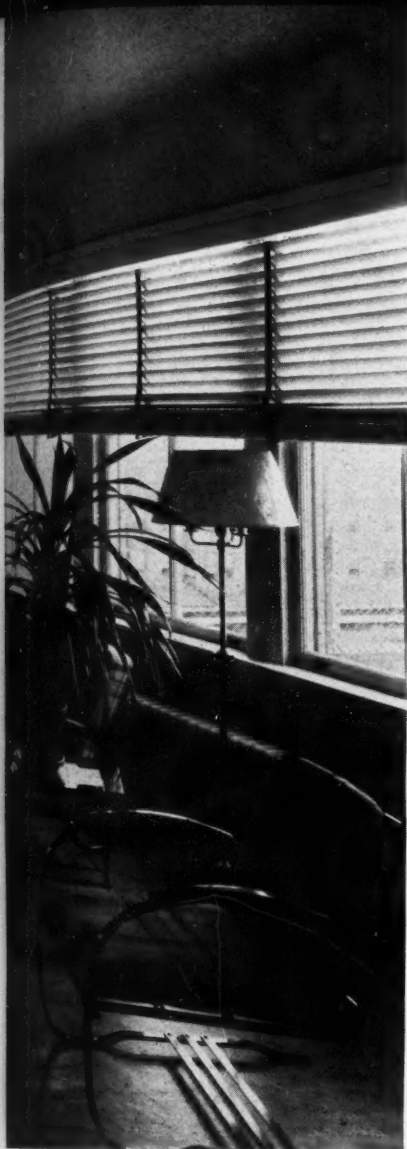
WHEN they coined the familiar phrase "Atlantic City — the Playground of the World," the hospital pattern was set. That hospital must answer the call of millions from every quarter of the globe who come somehow, some way — by motor, bus, railroad, boat or plane — to satisfy their yearning for lungfuls of invigorating salt air, mouthfuls of chewy salt water taffy and promenades along that great stretch of boardwalk lined with its tiny bazaars, always colorful, entertaining, amusing. Hospital service here must be just a bit different from any other.

Bear this in mind, then, when entering the main entrance of the Atlantic City Hospital on Ohio Avenue just one block from the Boardwalk. It is a hospital serving a population that runs as

high as 500,000 on holidays; the Fourth of July and Labor Day, for example. Summer population averages about 250,000; in winter it is about 100,000.

The chances are an ambulance will dash by you and swing into the emergency entrance. A frantic honking of horns means a taxicab or automobile approaching with some unfortunate accident victim. One day this summer, and it was not an unusual day, some 150 cases were treated in the emergency room from 6 o'clock in the morning until 7 o'clock in the evening.

Main highways leading to the famous resort take their toll; the ocean wreaks its dire vengeance on those unmindful of its strength, and suffering and tragedy daily stalk the corridors of palatial boardwalk hotels and little rooming

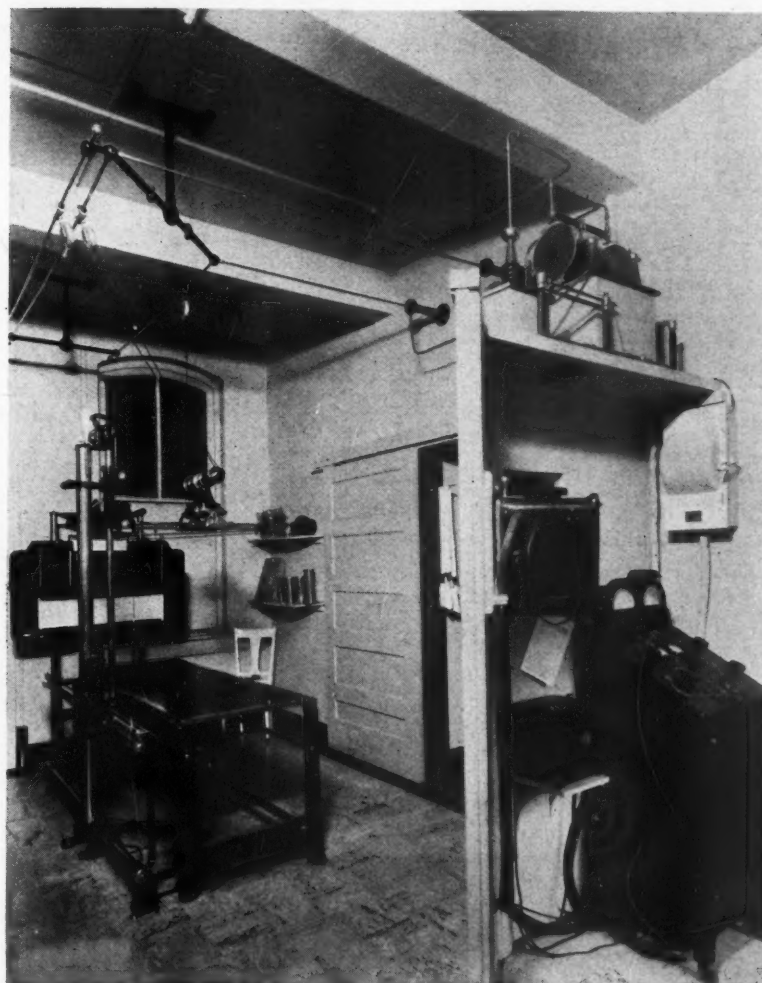


It was necessary to get up early to take this picture of Atlantic City Hospital—before the rush of the day's work started. X-ray department (below) and view of the solarium (opposite page).

By RAYMOND P. SLOAN

houses tucked away on the side streets. Accident cases last year ran between 6,000 and 7,000. Up to August 1 this year they numbered more than 6,000. There is never a dull moment in this miniature medical center, which must be all things to all people at all times.

Approach the hospital at visiting hours and you will find a serpentine line starting at the admitting desk, filling the lobby and ending on the sidewalk outside. Pity the poor flower vendor who stands close against the stone coping protecting his basket of brilliant blooms from this jostling crowd. Stand a minute in the few



feet of vacant floor space adjoining the office of the superintendent.

A call has come over the telephone from that ocean-side skyscraper hotel whose towers you can see through the window. Six nurses and doctors are battling to save the life of a guest taken critically ill. An oxygen tent is required, also suction apparatus. And can the hospital send someone along to help set up the equipment? Notwithstanding the fact that the engineer is occupied with a broken pipe line, he is summoned and put in charge of the emergency crew.

A second later comes another call. A visitor from Montreal, Canada, has dropped dead on the beach. Apparently he is alone. Instructions are issued to bring the body to the hospital morgue pending further developments. Incidentally the city has no morgue, the hospital's facilities being used by the coroner and the coroner's physician. Were we right in stating that life in Atlantic City Hospital is just one emergency after another?

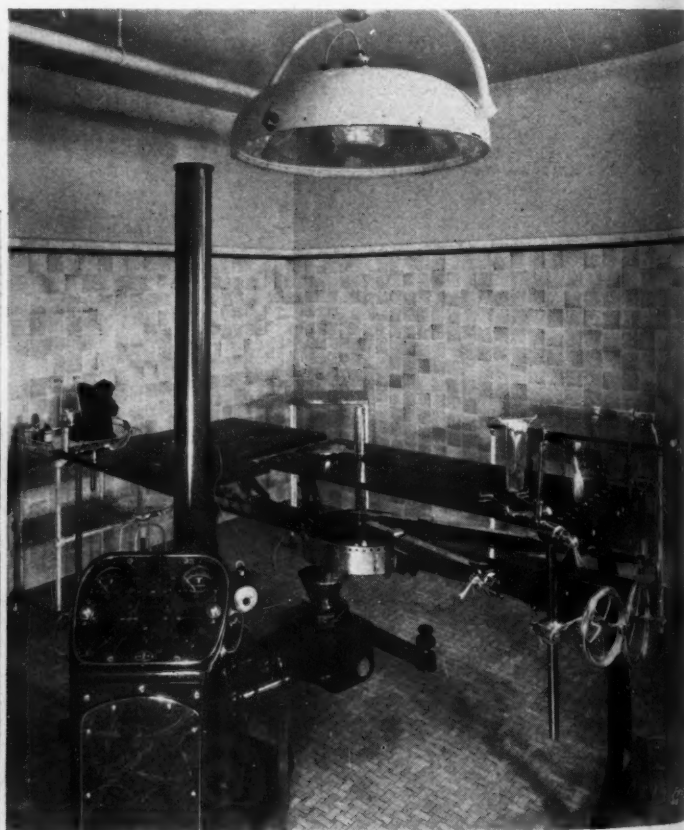
Atlantic City uses not only the hospital's morgue but all of its other departments. Care of the indigent sick, laboratory work for the city departments with the exception of ambulance service, pediatrics, obstetrics, orthopedics for other institutions—every phase of medical and surgical work is done for the city by the hospital. In return the city appropriates a certain sum each year for services rendered. Thus, while a voluntary hospital in the strictest sense of the word, it also as-

sumes the rôle of a city hospital. There is no other general hospital in the community. The only municipal hospital is a small contagious unit of sixty-eight beds which is also administered by the Atlantic City Hospital. All bills accruing from its operation, however, are turned over to the city for payment.

The relationship between hospital and city is entirely a happy one and wholly free from political entanglements. Management of the hospital rests entirely in the hands of the administrator and the board of trustees. The city merely pays for what it receives.

This additional responsibility, as is readily seen, demands hospital service efficient in every detail; also it demands equipment that is modern and embraces every known appliance for administering to human ills. There must be, too, an adequate supply to meet such demands as that described, when some hotel requests help. It is an unusual day indeed when some such request is not received. The hospital with its 316 beds also serves the adjoining territory for some forty miles, including the Cape May district.

As an illustration of this efficiency, many in



Every type of equipment is included—all of it modern and complete. At the left is the library where the doctors spend profitable hours. Note the book stall ready for a trip on the floors.

Atlantic City are still talking of the recent explosion that brought almost 200 victims to the hospital for treatment. The disaster occurred near the small municipal hospital. By the time the first patients were received, emergency stations had been set up in its building, and all were functioning smoothly under the supervision of nurses and other workers from the Atlantic City Hospital. More than 100 received first aid treatment, but more serious cases were, of course, removed to the general hospital. That, every one connected with the hospital agrees, was a day!

Perhaps the biggest emergency of all that has had to be met during recent years was one involving finances during depression days.

Money, at first scarce, soon disappeared completely and the entire city, including the hospital, was operated by the issuance of scrip. For three and a half years all local bills were paid in this way, even the interest on its bonds. Employees, too, received scrip, but only for a year. The sole exceptions to the rule were contracts existing with outside concerns. These were met with revenue from private patients.

This exigency existed not only in Atlantic City

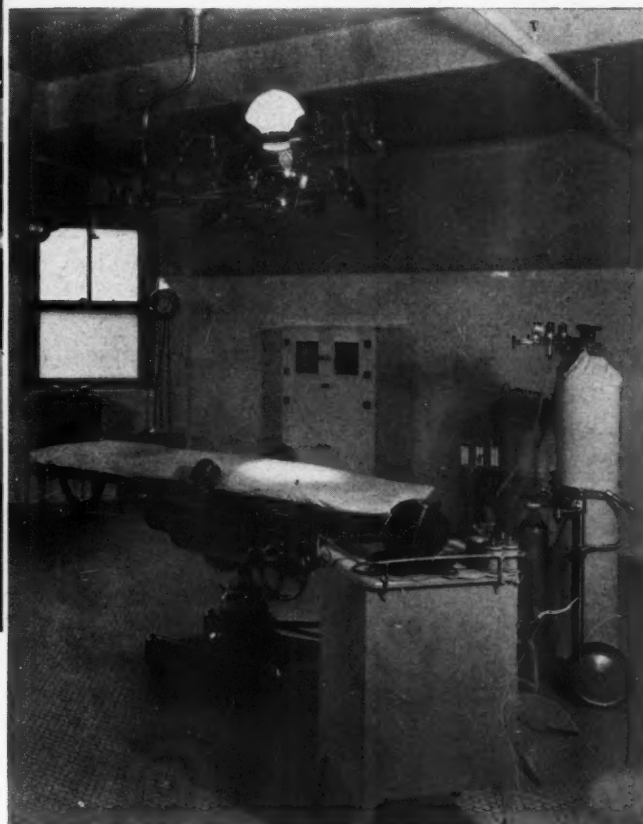
but in all the surrounding towns. The hospital was obliged to accept scrip in small denominations throughout its territory. The first step that marked a return to normalcy was the issuance of regular currency to employees. Notwithstanding these emergency measures, employees received only one cut of 10 per cent and that for eight months only. Today the scrip is fast disappearing.

The situation was not without its humorous side. It also had its tragic moments. Many were slow to learn that an unimportant looking bit of paper represented so many dollars. All agree, now that money is flowing again, that it was quite an experience. Certainly it could never have been accomplished with so little difficulty had it not been for the friendly relationship existing between the city government and the hospital administration.

The picture that the Atlantic City Hospital presents, therefore, is interesting—an institution faced with unusual situations, rendering an exceedingly active and extensive service, possessing no endowment, its revenue, except for the city appropriation, derived from its own operations and gifts received from friends, the women's auxiliary and the board of trustees. For those statistically minded it might be added that there are seventy-eight private rooms ranging in price from \$5 to \$10 a day with private bath. A total of 168 patients can be accommodated in semiprivate wards and rooms. The remaining beds are in wards.



Where the laboratory work is done, not only for the hospital but for the city and other institutions. The work covers all phases of medicine. The surgery stands ready and waiting (right).



Anyone inclined to study specialized service in hospital management at first hand would do well to spend some time at Atlantic City Hospital. The set-up is based on the assumption that no one receives new for old until she first returns the old—sound procedure at that. There is a central treatment service for assembling and sterilization of all linen dressings. All sterilization is done in one department. Even liquid nourishments are specialized, with two nurses in complete charge of the nourishment cards—little pink slips posted at the top of the bed listing the nourishment required for each individual patient.

Once each week new supplies are distributed provided those in use are returned. All returned goods are carefully inspected before being discarded. It is surprising what can be salvaged if the necessary care is taken in going over each item. "Think twice before destroying" is an excellent slogan.

Assuming that anyone would call at the hospital as early as 9 o'clock in the morning, which is unlikely, they would find a meeting taking place. Every day at that time all department heads gather in the superintendent's office. Hospital procedure generally is discussed with particular attention to complaints that may have been received or problems relating to any department that demand attention. These meetings may last a few minutes or consume an hour, depending on the ground that must be covered.

If perchance the visitor stayed over until 7 in the evening, he would find another meeting taking place, again in the superintendent's office. At this time the nursing head reports to the night supervisor the condition of the house and what patients will require extra care. Thus the night supervisor, without wasting time, knows the condition of those patients who are gravely ill and exactly where they are located.

Every Type of Clinic

Although every department of this hospital has been described as exceedingly active, no special mention has been made of the clinics. Those who respond to figures are again advised to take notes. Last year there were some 68,700 clinic visits from which exactly \$633.37 was collected.

Whenever possible to do so, clinic attendance is discouraged. All patients are given first aid, following which they are urged to return to their own doctors. If they have no doctor or know of none, names are supplied them. Should they come to the hospital from a hotel, they are advised to consult the management for the name of a physician. When they are unable to meet the expense of a physician, they are turned over to the social

service department. This in itself has been found to eliminate many who hesitate to subject themselves to any investigation that may prove embarrassing.

Every type of clinic is included in the hospital service. Particularly active is the venereal disease clinic held at the Municipal Hospital. Sometimes 200 patients attend this clinic, which is held daily. It must be remembered that Atlantic City is a resort town. It also has a large Negro population; in fact, approximately 20 per cent of the population is colored.

There is no more enthusiastic group of workers for the hospital than the women's auxiliary. This meets once a month in the nurses' home and through card parties and other special functions raises money for special funds and engages itself in various interests connected with the hospital and the nurses' home.

Besides this group, recently there has been formed a women's surgical dressing unit comprising some forty colored women who meet once a week at the Y. W. C. A. to make dressings. Only recently the colored business and professional women and school teachers of the city gave the hospital two oxygen tents.

Patient Is Always Right

As far as is consistent with medical procedure, the patient is always right at Atlantic City Hospital. Following the meeting of department heads, which takes place every morning in the superintendent's office, the room is notably empty. Everyone is at her station.

The only way to make sure that patients are satisfied and as comfortable as possible under the circumstances is to get around and talk with them. This is done every day. It takes time, of course, but how better can the administrator spend an hour or two than mixing with those she is serving and thus gaining their good will.

There may be some dissatisfaction over a nurse. Better move that nurse elsewhere than to have any trouble. Any nurse in the Atlantic City Hospital knows that the surest way to lose her position is to talk back to a patient.

Then, too, in a hospital that has even more than the usual quota of emergencies, how can the administrator judge whether or not they are being met successfully if she does not spend some time in the various departments studying the situation?

It all started when they made Atlantic City the "playground of the world." Right then and there it was agreed that there was just one thing for the hospital to do—"take care of them"—and that is precisely what it is doing today—efficiently.

Preview of Convention

PREVIEWS may be attended by invitation only. Invitations go to important people, the censors and the press. As no one feels more important than the press—unless it be the censors—let's forget small distinctions and sit down together, all we important folk, to watch the five-star drama of the hospital year unreel.

A superintendent has never been caught red-handed riding in a wheel chair in his own hospital no matter how many miles of corridor he must tread each day. But this is Atlantic City, and hospital executives clamber merrily into wheel chairs to be pushed in twosomes and threesomes down the Boardwalk to Convention Hall. Others stride briskly from hotel to meetings, and the thrifty early discover that 10-cent jitneys whisk down Pacific Avenue, the street back of the Boardwalk hotels.

Look—leaving the Ambassador are Bachmeyer and Father Griffin! Asa S. Bacon, too, is it not? And that's Mike Davis! They're off for the opening session, their reports sticking out of their pockets.

President Munger, looking more boyish and good-natured than ever after his trip to the Paris Exposition—or was it the International Hospital Congress?—now sounds the gavel for the first session in Laura E. Coleman Hall.

A note of sorrow here creeps into our drama. As in recent years, the convention halls are named in tribute to prominent hospital folk who have answered the final summons during the year. Laura E. Coleman Hall, Marie Louis Hall, Alfred C. Meyer Hall, Lewis A. Sexton Hall. They stir up memories, those four fine names.

Now for the Little Shows

To offset the tragic and to enliven the educational there are comedy rôles, in this mammoth production of the thirty-ninth annual convention. Twenty-eight reels, it runs, one for each session, not counting the shorts, news reels and trailers of concurrent conventions. From our preview, however, several thousand feet of film have been cut, so that we shall see merely a few high spots and novelty numbers.

Many little dramas go on within the big drama. The curtain goes up now on a hospital board room. A staff meeting is in progress, under the direction

of Dr. Joseph C. Doane, editor of The MODERN HOSPITAL. Participants in this dramatization of the work of an administrator are as follows:

Prologuer: Malcolm T. MacEachern, M.D.
Director of Ocean Hospital: Joseph C. Doane, M.D.
Assistant Director: Paul H. Fesler.
Assistant Director: Lewis E. Jarrett, M.D.
Dietitian: E. M. Geraghty
Superintendent of Nurses: E. Muriel Anscombe.
Occupational Therapist: Henrietta McNary.
Foreman of Grounds and Buildings: John Olsen.
Record Librarian: Mrs. Jessie Harned.
Director of Social Service: Ruth Lewis.
Housekeeper: Mrs. Doris Dungan.
Pharmacist: Miriam Russell.
Secretary to the Director: Lillian Miller.
Purchasing Agent: To be announced.

Fighting Fire

"Will some one from the audience please come up on the stage?"

This isn't Thurston, the magician, about to saw a woman in two. The call for a volunteer stooge comes from Fire Chief F. Stanley Howe of Orange Memorial Hospital. He has trained more than 500 employees—nurses, maids, orderlies, kitchen help, waitresses, clerks, technicians, social workers and telephone operators—in methods of fighting fire.

Chief Howe's dramatic fifteen-minute demonstration of hospital fire prevention begins.

A volunteer self-consciously takes the platform, his sole qualification being the fact that he has never before handled a fire extinguisher. He is introduced to a soda and acid extinguisher and told what is inside it and what makes it work.

Under Chief Howe's orders he practices the motions on an empty extinguisher. He then lifts a full extinguisher from a hook at regulation waist height, carries it approximately 30 feet to the door, inverts it at the entrance to make sure that it is functioning properly, then reenters the stage and plays it directly upon the blaze. He is taught to crouch behind the extinguisher and to keep it close to the floor, so that flame will not interfere with respiration.

At his own hospital, Superintendent Howe has a detached fire-resistive building used for waste storage and he conducts his demonstrations with blazing beds and dummy patients.

On the Atlantic City stage, Mr. Howe depends upon an imaginary fire, his own descriptive powers and a distribution of reprints on his methods.

HOSPITAL RECORDS IN COURT

A Comedy Drama in Three Acts

Produced by

L. M. ARROWSMITH

St. John's Hospital, Brooklyn, N. Y.

Another stage production unreels before our excited eyes. This is a reenactment of a play given before the New York State Hospital Association last May.

In the cast are the noted author and producer, Mr. Arrowsmith; that distinguished actor, James U. Norris of Woman's Hospital, New York City; another old trouser, Roderick Wellman, counsel for the United Hospital Fund, and two competent actresses with names new to Broadway, Mrs. Robert G. Cass and Marilyn Shepard, the latter a student record librarian.

The first act takes place in the record room, where the librarian and her young assistant wax indignant over those wily lawyers who try to get possession of records without authority.

Enters a sly lawyer and displays his usual oily tactics, but the librarians stand their ground firmly. As the curtain falls a court official enters with a subpoena for producing the records in court.

Act II takes place in a corridor of the court building. The crafty lawyer intercepts the young woman from the hospital and cajoles her into giving him the records. He breaks the seal, which should be opened only in court in the presence of the patient himself.

But the hospital's attorney is a witness of this illegal procedure, and the third act takes place in the judge's chambers. There the hospital attorney accuses the lawyer of committing a misdemeanor, with the result that the ambulance chaser—for such is his nefarious business—is fined by the court for improper conduct.

The Widow Consents

Dr. Malcolm T. MacEachern's persuasive powers, already of wide renown, are expended with ultimate brilliant success upon one newly widowed, in a dramatic dialogue of twenty minutes' duration.

Mrs. Robert G. Cass of East Orange, N. J., an amateur actress of talent, plays the rôle of the widow. Doctor MacEachern doubles as intern and attending physician.

The intent of this sketch is to show the hospital

that there is no standardized method of approach in asking consent for autopsy. Gradually, by means of kindly sympathy, Doctor MacEachern leads the distressed widow from a consideration of the general health of her husband prior to death to thoughts of her family, who might have inherited the same tendency, to other patients and to the future of scientific medicine. She is assured that the pathologist is a surgeon and that no disfigurement will result. She is reminded that insurance claims may be clarified. Step by step, there is built up in her the firm conviction that a postmortem examination is an excellent protection for herself, her family and for society.

ELLIS M. SMITH, M.D.
presents

ISOLATION HOSPITAL TECHNIQUE

Scene: Medical Aseptic Unit, Essex County Hospital, Belleville, N. J.

CAST OF CHARACTERS

Narrator.....	Ella Hazenjaeger
Mother.....	Mary Metily
Child Patient.....	Phyllis Smith
Nurse.....	Mary Metily
Ambulance Nurse.....	Ida Elliott
Ambulance Driver.....	Ellis M. Smith
Admission Room Physician.....	Ellis M. Smith
Aunt Ida.....	Ida Elliott

Procedures Demonstrated: Hospital aims; personal instructions to nurses; ambulance and admission room technique; care of patient's clothes; care of otoscope; transfer of patient; gown and hand technique; taking temperatures; kitchen technique; cleaning rooms; care of patient upon discharge.

A five-year-old child is ill in her home with scarlet fever and has been exposed to chickenpox. The mother has had children in the hospital before and therefore is cooperative in having the child transferred to the communicable disease hospital. In fact, the son is in the hospital at the present time with scarlet fever.

The foregoing situation pertains when Dr. Ellis M. Smith, assisted by Miss Hazenjaeger, director of nurses; Miss Metily, assistant director of nurses; Miss Elliott, supervisor, and Little Phyllis, Doctor Smith's five-year-old daughter, demonstrate on Tuesday afternoon in Lewis A. Sexton Hall the proper technique in an isolation hospital.

The stage for the second scene is set to show the admitting room, a corridor and the patient's hospital bedroom, complete with equipment.

Following the demonstration Doctor Smith and Miss Hazenjaeger answer questions.

Now we get a glimpse into the meeting of the trustees' section, just as William A. Sumner, president of Paterson General Hospital, quits the

(Continued on page 104)

Create No Privileged Class

Don't reduce rates for staff members. Discrimination in favor of any special class causes no end of confusion and probably in the final analysis displeases more persons than it pleases

By JOSEPH TURNER, M.D.

AN "EASEFUL" moment came to me on board ship today as I turned idly the pages of my favorite hospital magazine, albeit a copy many months old. The pages opened to the "Someone Has Asked" column and before my eyes appeared that hardy perennial, "What rate reduction for staff members?"

"Ah," thought I, "here is 'dat ol' debbil' problem that certainly should be solved by this time, for has it not been talked about and written on since long before my ancient intern days? Only the day before I sailed, did I not discuss it again for the hundredth time, or was it the thousandth?"

So with high hope I began to read the article, only again to have my high hope dashed to the ground. No help here, I could see; still straddling it.

In one of the leading county medical journals I read recently that "a grant of private room service to . . . doctors would not tax the resources of . . . (hospitals) severely and would be a courtesy (sic!) both deserved and appreciated by the profession." Occasionally, brace makers, optometrists, pharmacists and surgical supply houses have been known to show "courtesy" to some who were "deserving and appreciative," but has not this practice been described with harsh words by the nobility of the profession? In these circumstances, is not the term "courtesy" an euphemism for a practice that means a gift, a rebate, a bonus, or in some circumstances, an offer of charity based on factors not necessarily related to the recipient's economic or social eligibility for such assistance

and not applicable to other nonprofessional candidates for the same service?

A few writers in the past—before 1929—referred with lofty feeling and sentiment to hospital work as a service to the sick, the needy and the poor, or as a service to the community; or, in a more exalted spirit, as a service to "humanity." These words were always music to my ears. Only in a low voice was the business of the hospital—its collections, its costs, its budgets—allowed to intrude, and then usually in apologetic tone. There was, in those days, more concern over what the patient received, and less with what he gave or paid, not that the necessary business side of the hospital was not conducted in a business-like manner.

With the reading of this particular editorial, my initial feeling of happy expectation evaporated and my high spirits drooped. The writer evidently had not examined the fundamental issues involved and was mixing service with business, ethics with expediency. Rate reduction was described as a method of getting a "high type of loyalty." And in a similar vein "some hospitals entirely frank service fees . . . it is good business . . . to adopt a picayune policy is to fail to take advantage. . . ."

Why stop here? Why not be really consistent and logical and point out that loyalty can be obtained in many other ways? One might fill the satchels of the visiting doctor with bandages and drugs, one might supply him with anesthetic gases. Business houses entertain "buyers" to help sell their products; why not hospitals?

Actually Asking for Charity

But are we all talking about the same thing? Do hospitals give ward care at less than cost as a public service to the underprivileged who are unable to pay the costs out of their own resources? Do they give private service at charges predicated on the cost of service to those who can pay their way? If the latter service is given at a reduction (rate reduction implying private service given at less than cost) is the beneficiary of the reduction entitled to receive this charity at the hands of the hospital's supporters? Does the beneficiary in this case realize that it is actually charity that he is asking for and receiving and that sometime,

somewhere, somebody else must pay in the end to make good the difference between what it costs to give the service and what is received for it?

What is the real issue in this question entirely devoid of sentimentality and expediency? It is simply one of special privilege, not courtesy, to a special class for which the contributing public pays.

Some doctors claim to serve the hospital. If so, whom does the volunteer doctor serve? Is it not more accurate to say that he renders service to the sick poor in collaboration with a hospital which shares with the medical profession the burden of caring for individuals who cannot provide hospital care for themselves? To put it in other words, the charitable public, through hospitals that it builds and supports with money and service, together with a medical staff, serves the sick. The doctors do not serve a hospital, they serve the patient through and with the hospital.

No Place to Stop

The rebate is sometimes claimed merely on the ground of being a physician. Some physicians have no hospital connection whatever and in that sense render no public service through a hospital. There are others with only courtesy connections, limited to the pay parts of the hospital, who make no contribution toward the care of the sick poor. Still others may have given some public service at one time or another, but have given up this work. Would these also merit this gratuity on the part of hospitals?

The suggestion that special price concessions be granted to doctors and doctors' families is, of course, not a new one. It comes up in many forms. Many of the profession have ventured to justify it on the ground of services rendered to poor patients of the hospitals. On this same basis, requests for special consideration also have been made on behalf of nurses, medical social workers and other hospital workers whose pay is meager. Some have gone even further to argue that other forms of valuable services rendered to the community in general should merit discounts on the part of hospitals; these include clergymen, teachers and social workers not connected with hospitals.

Requests for rates below schedule have been made in behalf of relatives of liberal subscribers to the hospital, contributors to welfare chests and some who were liberal contributors in their more affluent days but who have come upon hard times. When discrimination in favor of any special class is once started, it may end anywhere; it certainly causes no end of confusion.

There is frequently an assumption in some of the requests for special rates that private room

rates are exorbitant. I do not know the practice in all hospitals, but in the one that I know best and in a few others, rates are based upon a careful study of actual costs and a reduction in any rates would mean a direct or indirect contribution on somebody's part to make up the difference. The hospital cannot conduct its pay or private service on a special (less than cost) rate for a privileged group without dipping into its trust funds, unless it raises rates to the other non-privileged classes.

A business house that carries on in this way and gives discounts to certain classes makes it up in other ways or pockets a certain percentage of loss; in any event, it is the owners or stockholders who make the contribution. But any failure on the part of the hospital to collect its private room rates (assuming that they are based on cost) can result only in the transfer and misapplication of funds given to it by the charitable public for the support of the poor in its public wards. There are no other sources from which these discounts can be reclaimed. Any automatic transfer of the hospital's charity funds to its private room account like this would be playing fast and loose with a trusting community that thinks it is supporting free work with the poor and not the privileged.

If once started, where can the line be drawn eventually? Once established as a precedent, do not other classes or groups tend to press requests for special consideration? It is not inconceivable that special rates finally may be asked for as a matter of individual merit as well as for membership in a privileged group. A few years ago, I received a request for special rate from a non-medical man who thought it would be appropriate in view of his own special services to the medical profession. The whole problem is fraught with difficulty, take it any way you will, but the proper approach to it is to create no privileged class.

Account Checking Simplified

A check of patients' delinquent accounts will be made much more easily if at certain intervals—for example, every six months—the color of the ledger sheets is changed. In going through the files of these old accounts the person checking can at a glance tell just how old they are. Only three or four colors are needed in such a scheme, as these colors may be rotated. No additional expense is involved in obtaining the various colors, as the quantity of each can be specified when the paper is selected and the forms are printed.—*Frank J. Walter, St. Luke's Hospital, Denver.*

Council of Congeniality

By MOIR P. TANNER

A RECENT report from the American Hospital Association on hospital conferences and superintendents' conferences makes this statement in reference to the latter: "One gathers from the reports that there is more discussion than action, which is to be expected when the group includes only superintendents who must defer to their trustees on matters of hospital policy."

The Western New York Hospital Council is a conference for hospital executives located in the following eight counties of that section of the state: Niagara, Orleans, Genesee, Wyoming, Erie, Chautauqua, Cattaraugus, Allegany. Its membership is not limited to superintendents, but assistants and supervisors of nurses and other authorized representatives of hospitals and clinics in the territory also take active part in the meetings. No institution, however, is allowed more than three votes.

At a recent meeting it was brought to the attention of the members that the organization did not strictly adhere to the definition of a council as the personnel included some members who did not fulfill the standard requirements. It was suggested some change might be in order, but it was unanimously the opinion of the members to make no changes whatever in the organization.

The object of the organization as stated in the constitution is the promotion and realization of progressively higher ideals in hospital administration. It serves as a central clearing house for discussion and possible solution of the many problems of hospital administration.

Never a Dull Meeting

Never has there been a dull meeting and many interesting and constructive discussions have taken place. For the last two years, it has been the policy of the organization to devote part of the meeting to a program of some special branch of hospital work. The pharmacy was thoroughly presented by several hospital pharmacists. The engineers of other hospitals took charge of another instructive meeting. The nurses had a program in which the dean of the school of nursing at the University of Buffalo presented the university plan of training nurses. The housekeepers,

dietitians and even the telephone operators are planning programs for subsequent meetings. Bringing department heads into meetings of special interest to their work has proved exceedingly valuable. The council sponsored an exchange of visitations so that these heads might spend a half day with one another and profit by others' ideas and methods.

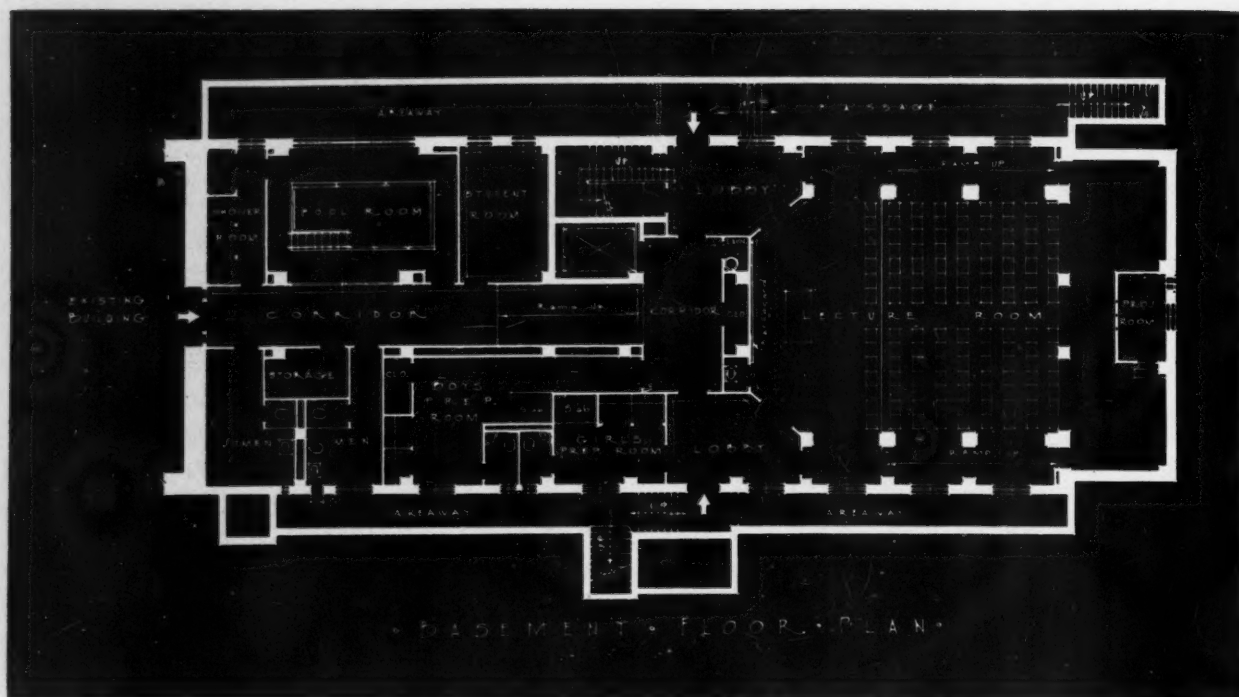
Legislative matters have received much attention of late, with extremely satisfactory results. Personnel management has come in for its share. Establishment of group hospitalization was one of the accomplishments of this conference. It was through this medium that pathologists and morticians came to a congenial agreement concerning autopsies. Many other purposes are being fulfilled, such as adoption of uniform visiting hours and study of the nursing situation in Western New York. The council has a standing committee which works with welfare departments in an effort to secure better per diem rates for public charges.

Publicity Pulls Attendance

At the last meeting of this group, a round table day proved a most successful experiment. Approximately 90 per cent of the membership attended and brought many department heads, who participated in the section of the meeting affecting their departments. Guests invited from surrounding territories were most enthusiastic.

To obtain a high attendance proper publicity was essential. Besides newspaper stories, there was a long parade of letters to the members. Some of the letters were enlivened by caricatures of speakers and hosts. This series coupled with an interesting program undoubtedly was responsible for the large attendance.

Authorities in various fields who added to several subjects included the maître-d'hôtel of Buffalo's Statler, lighting engineers, experienced maintenance men, a director of laboratories, directors of training schools, a state legislator and a roentgenologist—a varied representation.



Kansas Constructs Ward



Corridor and nurses' station

IN 1935, following a private gift of \$60,000 for such a purpose, the University of Kansas Hospitals at Kansas City, Kan., envisioned plans for the erection of a children's hospital unit as an addition to the existing ward building.

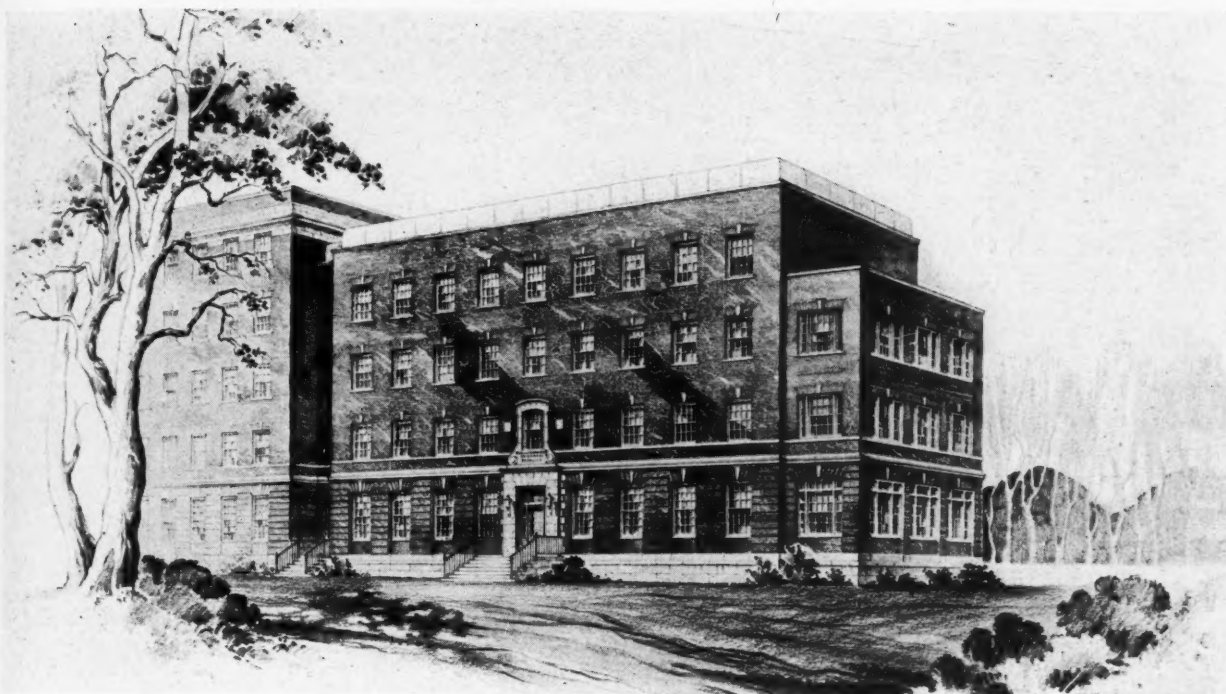
Preliminary plans for the new structure were worked out by the superintendent in charge, planning with the state architect, Raymond A. Coolidge, and with Samuel Hannaford and Sons as consulting architects. Final drawings were worked out in the office of the state architect.

Approval of a PWA grant swelled the total sum available for the building to \$107,641. While final working drawings were in progress, the excavation for the building was accomplished by the use of PWA labor, the project creating work for hundreds of needy relief clients in the Kansas City district. All excavation was completed ready for precise grading for column footings.

Contracts were let for construction of the building in January, 1936, and the work was completed in the middle of February, 1937.

All required services for the new addition were available in the adjacent structure.

In designing the children's ward, a definite break was made where it connected with the existing building. This emphasized the new portion



Building for Children

By CHARLES L. MARSHALL

as a unit and as a gift to the complete hospital plan. Its entrance, toward the street, gives access into a memorial lobby, finished in Philippine mahogany paneling, with marble base and hand-laid floor of cork tiles.

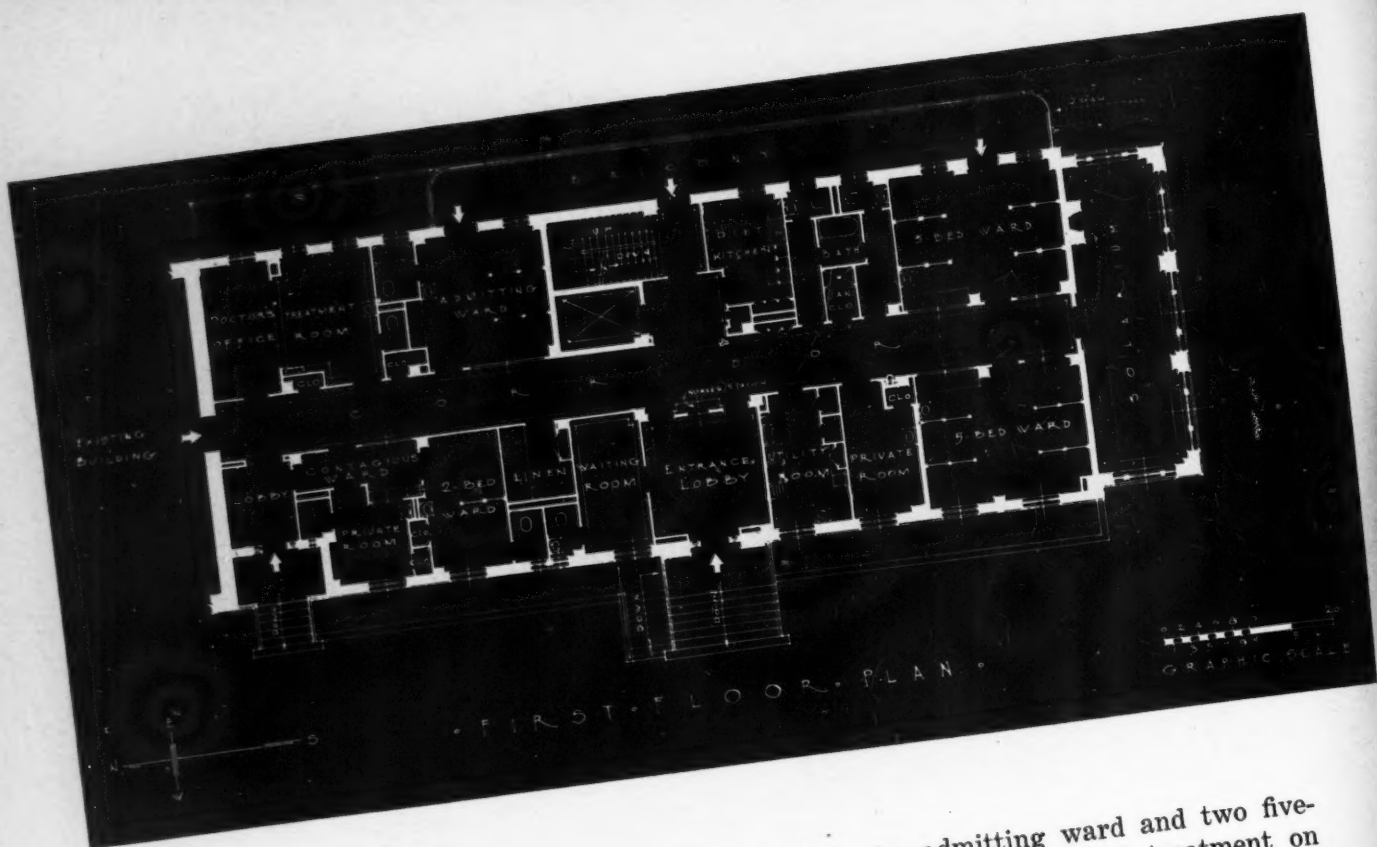
The building is 115 feet long by 42 feet wide, four stories high, with a full basement story. The design of the exterior is in keeping with the feeling of the entire institution, without being a replica of preceding buildings. A feature of the east elevation is a series of cantilevered porches, opening from the ward rooms, so patients may be outdoors for heliotherapy and convalescence.

Owing to the nature of the existing buildings in plan and to the peculiarity of the site, it was necessary to have a basement to meet an important floor level of the adjacent building. This required the use of areaways, but as the basement was planned only for services and a lecture room, this was not objectionable. The basement plan includes a much needed lecture and demonstration room, with near-by preparation rooms for child patients and a pool for crippled and undernourished children who need mechanical and physical therapy.

The first floor, besides the lobby, nurses' station and visitors' room, has a doctor's office with ad-



Typical sun room

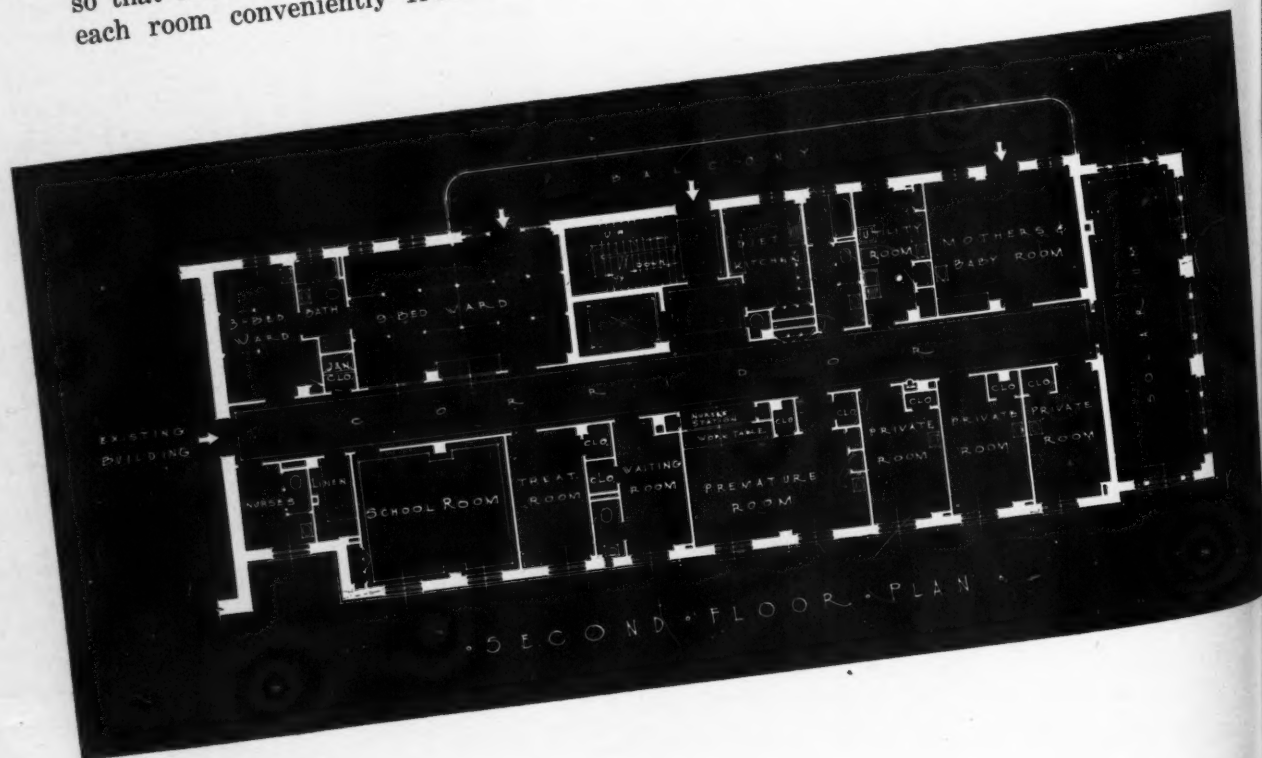


ja cent treatment room. These two rooms are separated by a folding partition which permits the use of this space for demonstrations for a small number of students. A soapstone work table is available for the doctor.

An isolation ward contains work space and a private and two-bed ward, planned so that the nurse in charge can see into each room conveniently from her work

table. An admitting ward and two five-bed wards with acoustical treatment on the ceiling, and a long solarium 11 feet by 36 feet 7 inches, with a fireplace, and the diet kitchen, utility and bathrooms complete this floor.

Of interest on the second floor is a room for premature infants, air conditioned, with double glazing in the exterior windows. Adjacent is the visitors' room with



An air conditioned room for premature infants with double glazing in the exterior windows. As a protection, there are viewing panels for visitors and nurses.



On the second floor is the children's schoolroom, one corner of which is shown. The drummer boy design in the center is inlaid in the linoleum floor covering.

a viewing panel between. The room for premature infants is arranged adjacent to the nurses' station for this floor, with a viewing panel so that the room may be given constant attention. It is entered through an air-lock vestibule using a double set of doors.

The second floor also contains a nine-bed ward for infants, a mothers' and baby ward room, a schoolroom, and private rooms and services.

The third and fourth floors are similar in arrangement, the room for premature infants becomes a three-bed ward, and the schoolroom a demonstration room. The roof will have a metal guard rail of wire mesh and will be available for convalescing children, with the intention of later having an enclosed shelter for additional protection.

Private rooms and ward rooms for adult use have doors 3 feet 8 inches by 7 feet. Other ward rooms have doors 3 feet 6 inches. Other doors generally are 3 feet by 7 feet. Ward and private

rooms are equipped with a secondary flap door of light frame and curtain paneling to afford privacy when the heavier doors are left open. These doors carry the room number and a name plate.

Rooms are heated by recessed copper cast radiation with metal cabinet enclosure. On both first and second floors provision has been made for future air conditioning in the ward rooms. Ducts have been roughed in, and a compressor room allotted in the basement, with exhaust duct installed to the outside.

Windows are of double hung sash, with marble stools. The bottom rail is 5 inches deep, which allows the bottom sash to raise $1\frac{1}{2}$ inches without opening to cause a draft, yet provides a $\frac{3}{4}$ -inch draft opening at the meeting rail.

Floors in general, throughout ward rooms and hospital service rooms, are of terrazzo with 6-inch base and 8-inch border. Corridors have terrazzo base and border with a $\frac{1}{8}$ -inch sheet rubber field. The schoolroom has linoleum with an inlaid design.

The building is designed to serve eighty patients, and provides teaching facilities for the 140 students in the junior and senior classes of the medical school of the University of Kansas.

Your Laboratory's Competitors

ANY consideration of factors that tend to lessen the work of the hospital laboratory must include competing elements met with by the entire hospital. These seem to be growing in number and in seriousness each year. Conditions affecting the outside practice of the staff doctors have a direct effect upon the laboratory. This is more marked when the hospital is within fairly easy reach of most of the patients and the laboratory has these patients from office or home practice referred directly to it.

The proportion of total hospital work performed by government hospitals is enormous, accounting for some 77 per cent of the total hospital days for the year 1935.¹ Much of this volume may be dismissed from the private hospital group as being made up of mental or tuberculous cases or hopelessly poverty stricken patients of all kinds. Yet an uncomfortable number are other types of patients who could and would pay moderate hospital costs if the service were available and if free care were not so easy to get. In 1930 the operating cost for care of mental disease and tuberculous cases in general hospitals was \$185,000,000, while that for general medical service was \$118,000,000.²

In addition, many of the government operated hospitals, especially county and city hospitals, have huge dispensary services. Many of these dispensary patients leave private physicians and institutions supported by them because they are educated by the insistent offering of free medical care to believe that it is their proper due.

Research Work Is Donated

A great amount of free clinical laboratory work is done by public health laboratories, most of which are under state or city control. Much of this has been given in carrying out the idea that all work along the line of disease prevention must be donated. As an example of the amount of work done in a single state, the laboratories of the Illinois State Department of Public Health performed 313,776 tests for the year 1933 to 1934. There were 198,921 blood examinations for syphilis.³ The public health laboratories often seek to justify extension of their service by the statement that it is demanded by physicians in the care of indigent patients. Since the work is done free, many physicians use the public health laboratories routinely

By H. R. FISHBACK, M.D.

for all the work that they will do. If the health departments were to organize personnel for doing sterility tests and Aschheim-Zondek tests, they could add countless thousands to their totals.

Free clinics or dispensaries, aside from those of state agencies, are operated from an increasing number of centers. Earlier clinics were almost all in association with medical schools. Now they are offered as a part of the activities of many private philanthropic projects. The total number of clinics was about 7,000 in 1931 and the patient visits in that year reached about forty million.⁴

Small Testing Cost

The laboratory work given clinic patients is often a small part of the expense of their total service. For diagnostic completeness it is frequently too little, if the amount of work done on patients with ability to pay is taken as a comparison. The following figures are from a representative clinic that charges a nominal laboratory fee to some patients. In one year the total number of patient visits was 160,067. The total number of laboratory tests run was 57,229. The income from these tests was \$2,358, giving an average of \$0.0412 per test. Taking the total clinic visits in the country as forty million,⁴ then the same rate of laboratory work would approximate thirteen million tests annually.

Groups of doctors, often with no other association than proximity of offices, find that a joint technician is a convenient aid in expediting simple laboratory tests, such as blood counts, urinalyses, smears and Kahn tests. The number of such groups is impossible to estimate, but in large cities they probably account for a considerable volume of laboratory work. Many technicians out of jobs during hard times have been able to build up such associations at a good profit to themselves.

The number of groups of physicians actually

Most hospital laboratories have enough space and facilities to take care of considerably more work. They could probably do all the laboratory tests required in the vicinity, thus avoiding unnecessary duplication

incorporated as clinics is rather few. In 1930 it was estimated that there were 150 clinic groups with an average of twelve doctors each.⁵ Most of such clinic groups take care of their own laboratory work at a profit.

Many private doctors train their office attendants to do their minor laboratory work. All too frequently doctors rest their conclusions on the work of such poorly trained assistants.

Factors in Price Cutting

Commercial laboratories thrive throughout the country. Originating in large cities, they have extended to smaller towns, and form a most serious competitor to hospital laboratory income. Several large companies have smaller units in surrounding towns along the chain-store idea of piling up a large volume business with central direction and cutting down of overhead costs. Many of these also hold hospital laboratory contracts; sometimes with a part-time director in attendance at the hospital, sometimes with a technician in actual charge.

The proportion of their "take" from the medical laboratory field is impossible to estimate, but an idea of a given locality may be obtained from Chicago, which has listed about 100 nongovernment hospitals with laboratories and about forty commercial medical laboratories. The actual proportion of the commercial work probably exceeds the proportion given above. In addition the commercial laboratories draw work from a wide area.

The passage of industrial insurance laws in forty-six states has brought many millions of workers under insurance protection against the hazards of employment. Many industries also offer medical service to their employees, varying in its extent and completeness.

Corporations with a large number of workers have found it advantageous to provide general

health care in addition to the required care of industrial accidents and sickness. This is further extended at times to include general care of illness in the workers' families. Laboratory work in connection with such activity, even though in minimum amount,⁶ compared with private patients, is lost to the local hospitals. With the huge number of insured and the further extension of corporation practice this might well be a most serious loss to hospital laboratory income. What difference the inclusion of sickness as a matter for company care will make is shown by the estimate⁷ that as a cause of absence from work, accidents make up 7 per cent of the total, occupational diseases, 3 per cent, and other sickness, 90 per cent.

Periodic health examinations have been offered to the public by several organized groups. Credit for pioneer work and publicity must go to life insurance companies. If private physicians and hospitals retain the lead as health examination centers they may also profit from the associated laboratory work. If, however, it is taken up by other organizations or associations, then these will expect to perform their own required tests.

Another example of health work is that offered by the student health services of colleges and universities. According to a report of the bureau of medical economics of the American Medical Association,⁸ in 237 schools having health service, there were 414,192 participants. The cost varied from \$5 to \$25 per year and the service ranged from simple dispensary aid to complete medical care.

In some universities the problem is taken care of by the associated medical school and its hospital. In other places the local general hospitals are used for student care. Still others have built special school dispensaries and hospitals, necessitating a loss to the existing local hospital service.

** What Advertising Can Do*

Advertising clinics fortunately have remained few in number, so that their present total does not take care of any great proportion of the total number of patients. Figures quoted from such a clinic show the latent possibilities. The Public Health Institute of Chicago in 1929 gave 470,000 treatments. This is about three times the total of a good sized dispensary of any first-class medical school.

The laboratory of this advertising clinic was equipped to do clinical laboratory tests on a wholesale scale. Tests performed there in 1928 numbered 164,666. Laboratory work was taken in from outside doctors and outside patients in addition to that of the clinic patients. Several factors have combined to alter the set-up of this clinic as it was in 1928, but the figures it established

remain an open demonstration of what can be accomplished by advertising and shrewd business management.

Irregular practitioners constitute another problem. These include the osteopaths, chiropractors, Christian Scientists and mental healers, naturopaths and allied cultists, quacks and impostors. The number of practitioners in organized groups in this country is estimated as about 36,000 and the annual amount taken by them from patients at about \$125,000,000.*

If no profit is expected from the laboratory department and its service is considered purely as a part of the general service rendered by the hospital to its patients, then the laboratory overhead may be included in the general daily cost to patients.

If a profit from laboratory operation appears necessary to help maintain the hospital, then certainly means must be considered to increase laboratory income.

Increasing the fees is a difficult thing to put into effect. The tendency in large centers with heavy competition has been toward lower prices in the last several years.

The staff doctors may be urged to send more of their laboratory work to their hospitals. Many doctors are now patronizing outside laboratories because some special arrangement has been made concerning price or ease of getting laboratory work done. Doctors may be found who are irregular in their hospital affiliations and whose offices and patients are close enough to become patrons of the hospital laboratory.

Promotional Work Is Needed

Occasionally outside organizations have some laboratory work to be done but not enough to warrant hiring an extra assistant. Such prospects may include very small hospitals that may want their tissue work, serology, bacteriology and blood chemistry run outside, or industrial plants and larger commercial organizations.

The work of the hospital laboratory and the service it gives should be presented to the public ethically and in educational form, so that patients will understand the value of the tests. Much valu-

able work is lost because the doctors feel that their patients will object to paying even a moderate laboratory fee. A cause of grief in hospitals is the general lack of understanding by patients of the necessity of laboratory tests as a help in the diagnosing and following of illnesses.

Such educational work may be carried on by the staff physicians themselves. Laboratory directors may find opportunity to discuss the value of laboratory work before lay groups, perhaps over the radio as a part of general medical education.

Most hospital laboratories have enough space and facilities available to expand considerably the volume of work. Thus they might do all the required laboratory work in the vicinity. All other laboratory service then can be considered unnecessary duplication.

Watchman in Uniform

What value the police? Like the poor, they are always with us and like dentists are happily forgotten unless we want them.

Most hospitals in large centers always have police in attendance at the main entrance. The use of a uniformed watchman with police powers when possible is indicated even in smaller institutions. It is often possible to secure a man not on active list of the police department, who is granted permission to wear the uniform of the force, at the usual wage paid a watchman. Naturally, the superannuated and physically unfit must be avoided. The duties are essentially those of a floater, since regular rounds with a clock deprives the plant of this employee's chief asset, mobile emergency work.

His presence in the crowded lobby at visiting hours is beneficent. In plucking the discharged porter from the line in the cafeteria when a free meal seems his for the taking, in lifting the wanderer from his apparently secure position with his back to the toilet door and his feet braced against the fixture where he proposes to sleep it off, his value is manifest. As a sedative to a drunken, noisy and quarrelsome accident room group he is superb.

When you get your next watchman, try, if possible, to find one who has had experience as an orderly. Not infrequently the knight of the bed pan has aspired to and even attained a badge and a night stick. A little study will reveal how valuable the combination of this varied training can be to a hospital.—*Albert W. Buck, Ph.D., New Haven Hospital, New Haven, Conn.*

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Those Subsidiary Workers

By ERNESTINE BONG, R.N.

THERE is no doubt but that the subsidiary worker in the hospital field has come to stay. Realizing this fact, hospital educators and executives all over the country are confronted with questions similar to these: (1) What educational level should we accept as a minimum for their qualification for the position? (2) How many nonnursing or nursing duties should be assigned to the worker? (3) What percentage of the total nursing load should we plan for them to carry? (4) How much training should we give them? (5) Are we flooding the community with potential "practical nurses" by our educational program for them? (6) Should we require them to be licensed, and fix a standard title which will not vary with the institution or the locality? (7) What is an adequate salary for this group of employees?

These are only a few of the problems that we are facing. At the University of Colorado School of Medicine and Hospitals the question of qualifications, title and salary has been worked out to the satisfaction of the institution and the employees.

Education Is Requisite

We employ only high school graduates and give preference to the applicants who have had or are enrolled for further higher education, such as normal school or college work. Some of our subsidiary workers are former school teachers. Some are medical students who have been unable to finish their courses. Many are now enrolled for university work and are taking either extension or evening classes. We use the title of "ward helper" for the worker who is in more direct contact with the patient than the regular ward maid. The minimum salary is \$40 per month, with board and laundry included. A wage scale provides for salary increase, depending upon the length of service.

We do not believe that this type of employee should carry out any nursing duties, such as giving medications or certain treatments and steri-

At the University of Colorado Hospitals the duties of the hospital attendant have been clearly defined and the resultant training is for efficiency in nonnursing services

lizing equipment. Therefore we have a definite outline of their duties; a time schedule of their daily work on the ward is posted in a place convenient for inspection. This prevents conflicts between their work and that of the nurse, and both groups work together with cooperation and harmony.

Our staff of subsidiary workers is well stabilized. We attribute this to three major reasons: (1) the educational qualifications we set up as a basis for the position; (2) the health program that is in operation for them, and (3) the educational program that we are carrying out. This program was started last spring, and it has been carried through the fall and winter semesters with increasing enthusiasm and appreciation by both the employees and the executive staff of the hospital.

We planned weekly meetings for each group, one to include the ward helpers and maids, and the other the orderlies and housemen. We have called these meetings "conferences." The conferences are scheduled routinely each week and the attendance is practically 100 per cent. A definite, planned program is carried out, but it is not one that is imposed upon the employee.

At the beginning we started with a tentative outline covering various phases of their work, and presented the material by instruction, demonstration and discussion. During the discussion period suggestions for subject matter in which the worker was especially interested were solicited.

These suggestions have provided the instructor (the assistant director of the school of nursing) with a wealth of subject matter that has been used throughout the course as a basis for the program. The subjects covered have direct bear-

ing upon the work done by the employee. In the ward helpers' and maids' conferences we have taken up: hospital etiquette; personal appearance; care of oxygen tents; care of flowers; how to clean a bed after the discharge of a patient; how to make a closed bed; how to strip a bed; how to open a bed; how to make a fracture bed (with and without the cradle); how to prevent infections; a discussion of venereal diseases and carcinoma; the soap suds enema; the preparation of a patient for the operating room; how to make the anesthesia bed, and care of the anesthesia patient. The method of presentation varies according to the subject.

Group Chooses Own Topics

Interest is maintained because of the participation of the group and because the topics are of their choosing and therefore represent their major interests. With such a program we feel there is no danger of turning out "practical nurses," and yet it is of great value to both the employee and the institution. The employee naturally becomes more efficient, she is happier in her work, she feels that someone is interested in her and in what she is doing, and she knows there is an appreciation of work well done.

These conferences are not yet organized to cover all of the work done by the subsidiary worker. Some of the teaching, especially of new employees, must necessarily be done by the head nurse. However, these classes do aid materially in lessening the burden of teaching. By close cooperation between the head nurse and the instructor many topics in which instruction is necessary for all members of the group are taken up in the conferences.

Classes for orderlies and housemen are conducted in much the same manner. As the orderlies are a stable and intelligent group, their classes have been especially worth while, and their contribution of great value. They take active part in the discussions and prepare demonstrations whenever such a presentation is indicated.

The following is a partial list of topics that have been covered during the fall and winter semesters: general care and appearance of the ward; use and care of the oxygen tent; symptoms of and care of the anesthesia patient; routine for admitting a patient and care of his clothing and valuables; routine for the discharge of a patient; what abnormal symptoms to note and report to the nurse; discussion of symptoms of disease prevalent at the time and reasons for treatments ordered, such as pneumonia, carcinoma, nephritis, G-U conditions, alcoholism; the soap suds enema and retention enema, with a demonstration of the

correct procedure and a discussion of principles involved and precautions necessary to observe.

First aid and emergency nursing have also been requested and taken up in these classes. Several talks on venereal diseases were given by one of our staff physicians, and a motion picture on oxygen therapy and the care of the oxygen tent was arranged for through the courtesy of one of the commercial oxygen companies.

We feel that these conferences or classes are a step in the right direction and are of great value in educating the subsidiary worker for the place that he fills in the hospital organization. As the eight-hour day becomes more universal, we may find that we shall depend more and more upon this group for the routine service. Our aim is always the highest and best type of care we can provide for our patient. Therefore we must give serious thought to this group of employees who are always in constant contact with the patient and are responsible for many of the small services rendered him. They must be carefully selected, carefully supervised and thoughtfully trained and stabilized to make their contribution to the patients' welfare of value, to help them improve themselves, and to guard the reputation of the institution that employs them as one in which the patient is always the first consideration.

Courtesy in Autopsies

Some undertakers are opposed to the practice of autopsy because they believe it prevents adequate embalming of the body. Some oppose it because of lack of experience. The pathologist of the Tacoma General Hospital, Tacoma, Wash., uses his own discretion about leaving the blood vessels untied or tied, depending upon the circumstances, so as to make it possible for the embalmer to do the best work. He leaves the blood vessels long so that they are easily identified.

In an examination of the head, this pathologist inserts a plaster mold to prevent leakage of fluid that might disfigure the face. His incision does not extend from the neck down as so many do, rather he describes an arc from one axilla to the other. No incision shows even when a low-necked gown is placed on a woman.

In Tacoma, there is not a word of opposition from the funeral directors. Autopsies cause extra work for them and yet, on the other hand, they find it easier to embalm the abdominal cavity, as without an autopsy they can reach only a few pockets in the intestines.—*C. J. Cummings, superintendent, General Hospital, Tacoma, Wash.*

Medical Ward Practices

More than an amply stocked drug closet is needed for correct diagnostic procedures on the medical ward

By JOSEPH C. DOANE, M.D.

THE procedures carried on in the medical department may be roughly classed under two headings—diagnostic and therapeutic. Of the former group, the following may be set down as representative, if not all-inclusive: venous, chest, abdominal and spinal tap; aspiration biopsy for obtaining tissue for diagnosis; aspiration of joints or other cavities for discovering the presence of pus, and gastric, duodenal, biliary and urinary drainage. The therapeutic procedures may represent all of those mentioned since any type of exploration by needle may be both diagnostic and therapeutic. However, the injection of medicinal substances into the vein, spinal canal or under the skin is the more common type of treatment procedure observed in the medical ward.

More recently the continuous drainage by suction of the stomach and intestinal tract to which the name of the originator, Wangensteen, is attached has served a valuable purpose. The details of the administration of oxygen by means of one of the types of modern apparatus devised for this purpose are too well known to deserve more than mention. Of certain miscellaneous medical procedures, the use of newer study methods in the diagnosis of vascular disease and of a thermostatic bed cradle to maintain a constant temperature of the part enclosed may be mentioned as examples. Let us proceed to describe a few of these practices.

This is a time of laboratory study. The medical ward fairly hums with procedures that are aimed toward the prompt arrival at a correct diagnosis of disease. The collection of specimens that requires the exploration of cavities for normal or pathologic material consumes many hours of the hospital day for doctors and medical technicians.

Let us glance for a moment at a typical medical ward as the day begins. The collection of morning blood specimens is the first activity. This may be done by medical representatives of the laboratory force, by the ward junior intern or even in some instances by technicians. It is customary for those interns to whom this work is allotted to begin the collection of blood specimens soon after 7 o'clock in the morning. This is necessary to avoid delay not only in serving the patients' breakfasts but also in starting the day's work in the laboratory or in the ward.

About the time this task is completed, the physicians assigned to ward duty report. There are many practices, some routine, some unusual, that now must be undertaken. To carry on this work the equipment of each ward must contain certain instruments and supplies so that the intern may carry on efficiently. Three types of tubes for

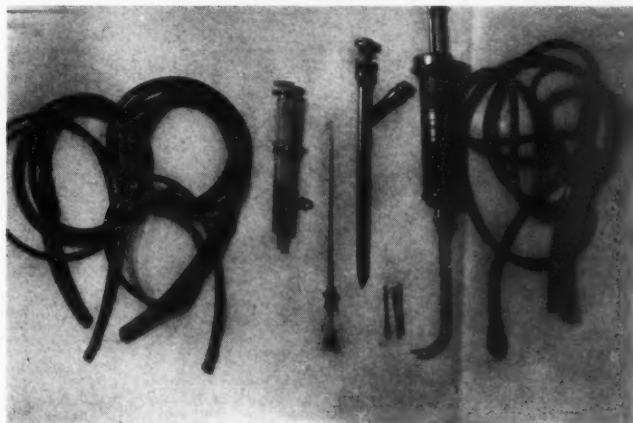


Fig. 1

withdrawing stomach and gall bladder specimens are in use (Fig. 1).^{*} These differ chiefly in the type of metal tip used and but little in length or size. A trocar and cannula for aspiration of the abdominal cavity, a syringe with L tip arising from the barrel for determining that a needle is in the vein before allowing a fluid to flow, a syringe for injecting iodized oil into the bronchi and the tiny silver tubes for withdrawing fluid from waterlogged tissues also are pictured.

^{*}Illustrations are of apparatus employed in the medical wards of Jewish Hospital, Philadelphia.

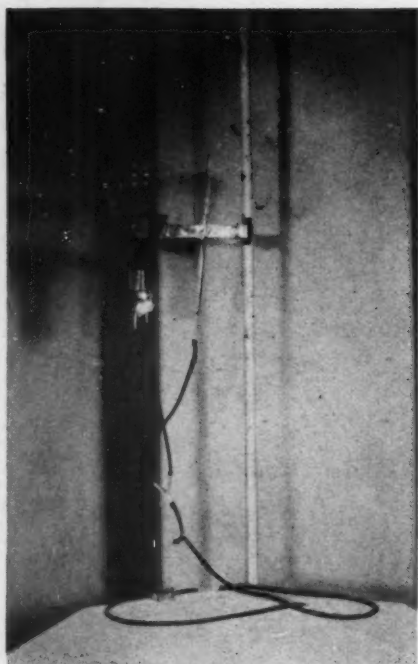


Fig. 2

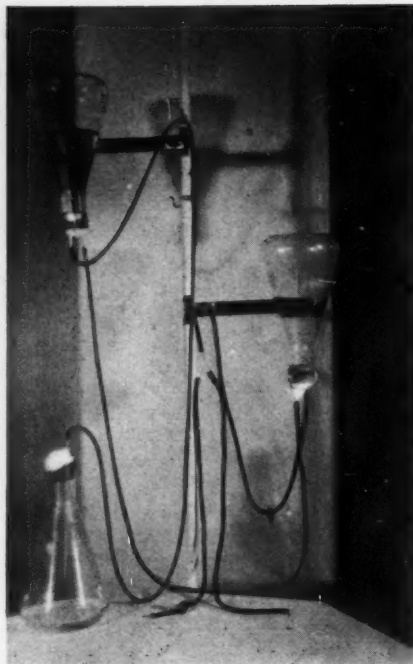


Fig. 3

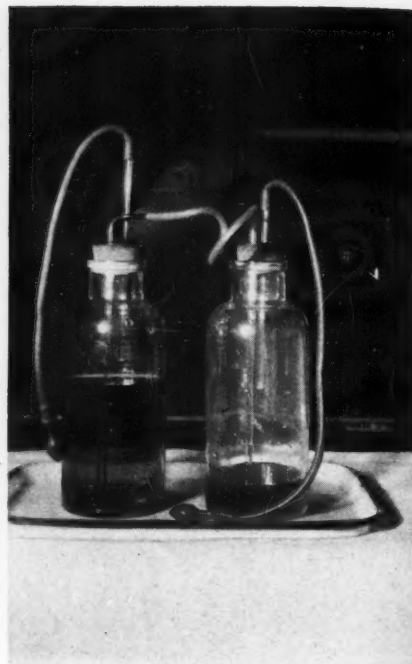


Fig. 5

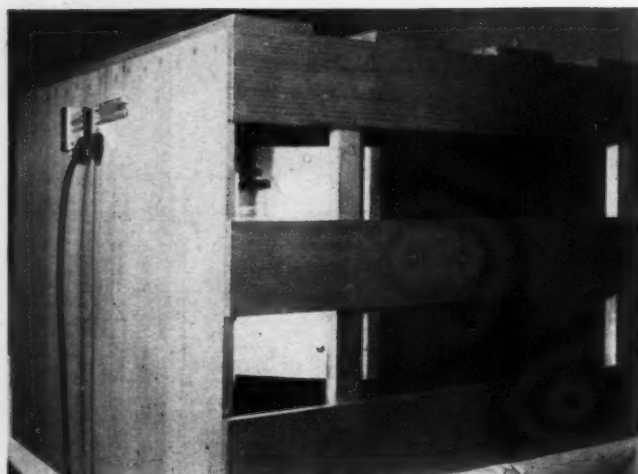


Fig. 4

A pneumonia patient who has been receiving intravenously 100 cc. of 50 per cent glucose solution twice a day must be treated. It is a common thing for patients who are suffering with toxemia or infections to receive intravenous glucose. A dehydrated patient must be given by vein 1000 cc. of 10 per cent glucose. It is customary for this solution to be administered for several hours. The apparatus used is shown in Figure 2.

There are other patients, particularly in the surgical ward, who require both fluids by vein and the removal of gas and fluid from the intestinal tract at the same time. By an ingenious arrangement of flasks and tubing supported on an ordinary ward clothes tree, these two procedures may be carried on simultaneously. In some hospitals an efficient but expensive apparatus with containers attached to pulleys and cords arranged on a metal upright is in use. Where there is to be found more in-

genuity and less money an equally efficient apparatus may be constructed by the expenditure of a few dollars for flasks and rubber tubing. This set-up is shown in Figure 3.

As will be noted in Figure 2, the same flasks supported by special brackets in which the solutions were sterilized are employed to administer them to the patient. They are stoppered by a perforated rubber cork with two glass tubes passing through it, one for the avoidance of a vacuum behind the fluid and the other for delivering the solution. Since the flasks must be inverted a special clamp is necessary to hold the corks firmly in place.

As we glance down the ward our attention is attracted to what appears to be a patient hiding behind a mountain of bed clothes. This is likely to be one who suffers with disturbance of the blood supply to his limbs. The mountain of blankets is in reality a thermostatically controlled bed cradle which is gradually replacing the old-fashioned hoops of wood or steel with an electric bulb suspended from within. The latter is inefficient and is likely to burn the patient. Moreover, the temperature of the enclosure cannot be kept at the steady level that is possible in the simple square box of slats with a thermostatic switch connecting the bulbs therein with a wall plug.

The cost of such an apparatus, which can be made by the hospital carpenter, is largely represented by the thermostatic switch, which may be purchased for from \$12 to \$15. With the increase of our knowledge concerning the treatment of vascular disease, diabetes and other conditions, this heat cradle finds an important place. Figure

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4 represents this simple, convenient apparatus.

When it is necessary to reinflate lung tissue that has been compressed for some time by pus or serum the blow bottles shown in Figure 5 are used. Here the patient transfers from bottle to bottle a fluid, usually colored water, by blowing air into one and thus displacing its fluid contents. By so doing the collapsed lung is gradually expanded.

The nurse now telephones to the central tray station and requests materials for performing a chest tap. The patient has pneumonia and the temperature, which had declined after several days, has risen again. The ward physician desires to explore the pleural sac for the presence of pus. If the patient is too ill to have been moved, a portable x-ray machine has been brought into use and the film is now available for the physician to assist him in locating the trouble.

The tray with 50 cc. syringe, with two-way stopcock, needles, sterile towels, small syringe for anesthesia, novocaine, sterile bottles and test tubes is brought and the intern scrubs, caps, gowns and gloves before he begins his work. If he is skillful no pain is given the patient except that produced by the initial needle prick. The ward is not alarmed by cries from behind the drawn cubicle curtain and all progresses in a quiet, skilled and efficient manner. To allow the patient to hear the gurgling of fluid flowing into a container during such a procedure is a highly improper technique.

This procedure finished, ward work is interrupted during the serving of the midday meal. Those who are considerate of the welfare of patients willingly relinquish the services of the ward nurses at meal hours.

Set-Up for Abdominal Tapping

A cardiac case with much fluid in the peritoneal cavity is to be relieved in the afternoon by abdominal tapping. A tray is again requested with many of the articles employed in chest tapping except that in place of a large syringe with a two-way stopcock, a generous sized trocar and cannula is employed. The same careful aseptic technique is employed.

One may also observe during the morning hours the several gastric or biliary drainages in progress. Gone are the days when a large, old-fashioned stomach tube buried in ice chips is brought to the bedside. One look at such a formidable tube was often sufficient to alarm the patient so that even though he desired to cooperate he could not. An innocuous looking Refus tube (Fig. 1), bottles for the collection of fifteen-minute specimens and, in the case of biliary drainage, a glass syringe for

the injection of magnesium sulphate comprise the articles on the tray.

In making gastric analyses the entire responsibility for withdrawing specimens at fifteen-minute intervals is assigned to the nurse. If she forgets to withdraw every specimen on time the results of the study may be rendered less valuable.

Sometimes when fluids cannot be administered by vein they are injected beneath the skin and the so-called practice of hypodermoclysis is carried out. While this procedure is relatively harmless to the patient, it is not without pain and the insertion and withdrawal of needles should never be left to the nurse.

It is evident that the study and treatment of medical patients require much more than a drug closet amply stocked.

No mention has been made in this article of the splendid therapeutic service rendered by the department of physical medicine and no medical ward is complete without such a service.

"Why Should I Wait?"

One of the important problems that troubles the hospital administrator when ward beds are in great demand is the best manner of handling patients on the waiting list.

As the administrator of every hospital knows, it is not an easy matter to explain to a sick man, his anxious relatives or his influential friends, the reasons why he must wait his turn for admission. A sick man is naturally more selfish than a healthy man. After all explanations are made, we frequently get the response: "Yes, but my claims to a bed come first."

Some time ago a friend of our hospital provided us with a very homely explanation which we have used with great effect ever since. He says to the family in effect:

"When one of you goes to the barber shop and sees people waiting their turn, would you ever think of asking the barber for preferential treatment while keeping the others waiting?"

Through long established custom the routine of the barber shop is so fixed that no one would think of demanding a place out of turn in violation of the rights of those who are waiting. From this point, the argument is a fortiori: "If you wouldn't do it in the barber shop, why do it in the hospital?"

The answer is, "We are not dealing with people who are well, but with people who are sick."—J. Goodfriend, *Montefiore Hospital, New York City.*



Baltimore Marine Hospital is an example of the modern type.

“H AVE man 28 years old, temperature 99.8, pulse 82, terrific pain in right side of abdomen. Has grown steadily worse last three hours. Have ice pack applied to side at present.”

This message received at the Marine Hospital in Galveston from the steamer *E. R. Kemp* 225 miles out at sea, bound for Boliver Roads, started an interchange of communications between the hospital and the ship in which the patient's condition was diagnosed as acute appendicitis. More radiograms followed, and the following morning Harry Hunter, seaman, was removed to the *U.S.S. Saranac* on which an operation took place about 100 miles out of Galveston. Later that day the patient was safely removed to the Marine Hospital for convalescence.

Hardly a day passes that such messages are not being received at the twenty-six marine hospitals scattered throughout the United States and answered as effectively as in the case of Harry Hunter. Such emergency measures are not always necessary, to be sure. Frequently the medical treatment suggested provides relief until the ship reaches its next port. Sometimes the procedure prescribed does more and effects a complete cure.

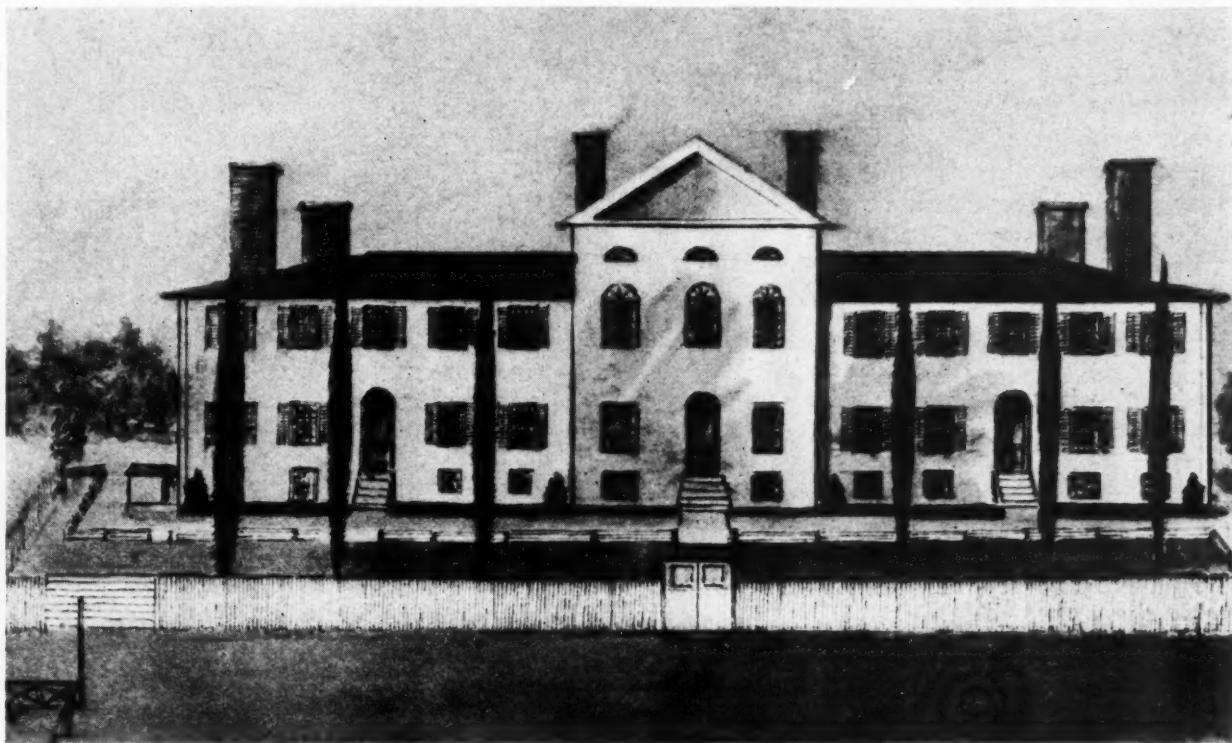
Hospitals of the

By S. L. CHRISTIAN, M.D.

The marine hospitals originally were established to provide medical care for a group of persons who not only lacked these facilities, but who frequently lay sick and helpless on their ships or in wretched cabins in various ports where they died miserably, often after subjecting humane persons among their countrymen to much trouble and expense.

Toward the end of the nineteenth century, however, and with increasing frequency ever since, Congress has passed laws greatly extending the scope of its activities and including public health functions. In 1902 the name of the Marine Hospital Service was changed by law to the Public Health and Marine Hospital Service and, in 1912, in keeping with the rapidly developing knowledge of public health, Congress enlarged the duties, changing the name to the Public Health Service.

In addition to the humanitarian aspect of pro-



Second U. S. Marine Hospital, Port of Boston, occupied 1804-27.

Merchant Marine

viding medical care for a group that had suffered unduly for want of hospitalization and medical treatment, the establishment of the marine hospitals was an important step in advancing the development of the merchant marine of the young American republic.

The first treatment furnished seamen by the Marine Hospital Service was given in Boston early in 1799, by Dr. Thomas Welch, who had assisted in caring for the wounded at the battles of Lexington and Concord, and was surgeon of the 27th continental regiment during the Revolutionary War. The first marine hospital was located at Washington Point, Norfolk, Va., and was purchased from the state of Virginia in 1801. The second marine hospital was built in Boston in 1803 and was occupied in 1804. As the country grew and its commerce expanded, other marine hospitals were established along the Atlantic sea-

board, on the Mississippi and Ohio Rivers, on the Great Lakes, the Gulf of Mexico, and finally on the Pacific Coast.

As previously indicated there are today twenty-six modern, thoroughly equipped marine hospitals of the Public Health Service located within the United States. It has been the policy to

build these hospitals only where it is more economical to do so than to provide hospital care for the beneficiaries by contract with private institutions. These twenty-six marine hospitals include two specialized institutions—a leprosarium and a tuberculosis sanatorium, both located to obtain climatic advantages.

The other marine hospitals are located in Baltimore; Boston; Buffalo, N. Y.; Chicago; Cleveland; Detroit; Ellis Island, N. Y.; Evansville, Ind.; Galveston, Tex.; Key West, Fla.; Louisville, Ky.; Memphis, Tenn.; Mobile, Ala.; New Orleans; New York City; Norfolk, Va.; Pittsburgh; Portland, Me.; St. Louis; San Francisco; Savannah, Ga.; Seattle, Wash.; Stapleton, N. Y., and Vineyard Haven, Mass.

These hospitals have a total of approximately 6,000 beds. The personnel totals 3,307, consisting of 278 physicians, 59 dentists, 522 nurses, 146

technicians, 268 consulting specialists and 2,034 other persons who provide the modern scientific medical, surgical, dental and nursing care to which marine hospital beneficiaries are entitled. In addition to these hospitals, the Public Health Service also operates 126 out-patient offices, or contract hospital facilities, in which 36 full-time and 110 part-time physicians and 51 full-time and part-time employees are on duty. The marine hospital at Chicago recently has been enlarged, and the hospital at Stapleton, N. Y., when plans have been carried out, will be a 1,000-bed institution.

The marine hospitals not only have all departments affording specialized service but are equipped with the most modern appliances for the diagnosis and treatment of disease—laboratory, x-ray, dental equipment, physiotherapy and hydrotherapy. Within recent years one of the larger hospitals, the marine hospital at Ellis Island, established a neuropsychiatric service, administered as an integral part of the hospital organization. During a one-year period neuropsychiatric and related diagnoses were made on 384 patients. The experience indicates that the creation of the neuropsychiatric service was a wise procedure, increasing the usefulness of the hospital by providing special care for certain types of patients whose problems are frequently overlooked in general hospitals.

The hospital personnel is no less important than the equipment, and every means is taken by examination and selection to obtain the best personnel possible. Marine hospitals are professionally staffed by medical officers who are both competent and humane. Internships are provided, and many of the marine hospitals offer valuable opportunities for interns because there are frequently cases of rare diseases and conditions which they probably would not see elsewhere.

In 1935 two of the marine hospitals were included, by the council on medical education and hospitals of the American Medical Association, in a list of twenty American hospitals approved for intern training that were most successful in necropsy performance.

Service at Low Cost

While marine hospitals provide a service comparable with that which the best private institutions afford, they are conducted economically. In the face of greatly advanced costs of commodities of all kinds, the gross per diem cost during the fiscal year ended June 30, 1936, was only \$3.39. This per diem cost is 83 cents cheaper than that of 1,016 hospitals that reported their costs to the American Hospital Association, the Catholic Hospital Association of the United States and Canada,

and the American Protestant Hospital Association for the calendar year 1933, during which year costs were much lower than they were during 1936.

Two of the marine hospitals are specialized institutions—those at Fort Stanton, N. M., and Carville, La. The hospital at Fort Stanton is for tuberculous beneficiaries whose condition is suitable for treatment at moderate altitude, and the selection of patients for this institution is limited to those with favorable prognosis. Although climate is regarded as less important now than it was when this hospital was established in 1899, its value for the purpose is none the less, because the location is fairly central for merchant seamen for the Atlantic, Pacific, Gulf and Great Lakes, and it is convenient for the prolonged care necessary to recovery of selected tuberculous patients.

Leprosarium Has 360 Patients

At the Marine Hospital, Carville, La., (the National Leprosarium), there are about 360 patients under treatment. This hospital was purchased from the state of Louisiana in 1921; it was formerly the Louisiana State Leper Home. Many of the patients in the leprosarium have entered voluntarily; others have been sent there by the health officers of various states. Encouraging results from treatment have been obtained, and in many cases the disease has been arrested and the patient discharged.

In providing this care to American merchant seamen, the marine hospitals aided and encouraged the development of one of the greatest merchant marines of the world. This group of American seamen is today the largest class of beneficiaries of the Public Health Service. A great part of the expansion of this service is due to the increase in commerce, but a part is also due to the addition by Congress of other classes of beneficiaries from time to time.

In addition to merchant seamen, the present classes of legal beneficiaries of the Public Health Service include the men of the U. S. Coast Guard, civil employees of the federal government, the personnel of the coast and geodetic survey and the lighthouse service and certain pay patients.

Merchant seamen constitute about 60 per cent of all marine hospital patients. These patients are gathered from all parts of the world and are afflicted with practically all known diseases of mankind, requiring thoroughly trained and widely experienced physicians representing all the specialties of modern medicine and surgery. During the year ended June 30, 1936, 1,153,480 days of hospital relief and 622,188 out-patient treatments were furnished seamen by the U. S. P. H. S.

CLASSES OF BENEFICIARIES AND AMOUNT AND CHARACTER OF SERVICES RENDERED DURING THE FISCAL YEAR 1936
Summary of services by class of beneficiary

Class of beneficiary	Hospital Days		Out-Patient Treatments		Physical Examinations (not related to treatment)		Remarks
	Number	Per Cent of Total	Number	Per Cent of Total	Number	Per Cent of Total	
American merchant seamen.....	1,109,748	58.27	598,761	46.36	9,063	8.33	Communicable diseases are reported to local health officers.
Veterans.....	130,539	6.85	1,202	.09	1,136	1.04	Patients of the Veterans' Administration.
Lepers.....	136,035	7.14	7	.....	2	.....	National Leper Home, Carville, La.
Coast guard personnel.....	88,325	4.64	130,206	10.08	5,149	4.73	All medical services and supplies, ashore and afloat.
Injured federal employees.....	95,451	5.01	119,837	9.28	23,741	21.82	Patients of the Employees' Compensation Commission.
Immigrants.....	24,487	1.29	10,759	.83	1,258	1.16	Patients of the Bureau of Immigration.
Seamen, engineer corps and army transport service.....	43,732	2.30	23,427	1.81	1,222	1.12	Civilian employees on Army Vessels.
Seamen from foreign vessels....	6,058	.32	867	.07	44	.04	Pay patients.
Seamen and keepers, lighthouse service.....	14,582	.77	6,772	.52	161	.15	Medical supplies also furnished to lighthouse vessels.
Civilian Conservation Corps....	170,798	8.97	1,950	.13	1,252	1.15	Patients of the Civilian Conservation Corps.
Civil Works Administration.....	9,429	.49	1,673	.13	318	.29	Patients of the Civil Works Administration.
Works Progress Administration..	48,762	2.56	82,858	6.42	17,579	16.16	Patients of the Works Progress Administration.
Alaska cannery workers leaving United States.....	.....	.....	990	.08	7,277	6.69	Vaccinations and other preventive measures.
Pilots and other licenses.....	.....	.....	.....	.....	7,306	6.72	For the Steamboat Inspection Service.
Civil service applicants and employees.....	.....	.....	.....	.....	25,409	23.35	For the Civil Service Commission.
Shipping board.....	.....	.....	.....	.....	1,357	1.25	To determine fitness for sea duty.
All others entitled to treatment.	26,395	1.39	312,307	24.18	6,533	6.00	From Bureau of Fisheries, Army, Navy, Mississippi River Commission, Coast and Geodetic Survey, etc.
Total.....	1,904,341	100.00	1,291,616	100.00	108,807	100.00	

On June 30, 1936, the officers and enlisted personnel of the Coast Guard numbered about 11,000, stationed on seagoing cutters, patrol boats, airplanes, and at lifesaving stations along the coast. These were furnished about 7.5 per cent of the total hospital days during the fiscal year 1936.

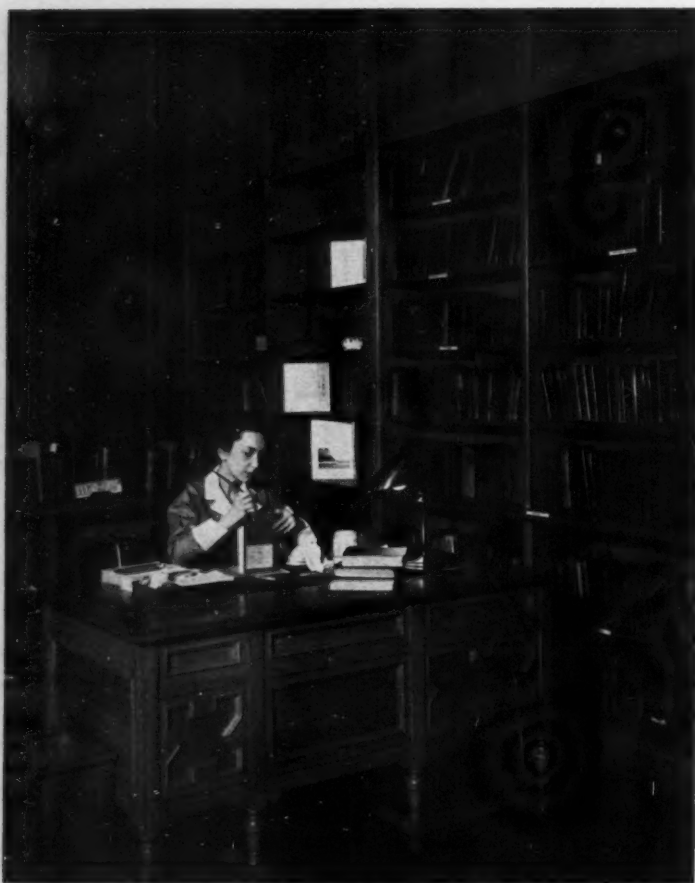
Civil employees of the United States government injured in the performance of duty and those contracting occupational diseases are entitled to all necessary medical relief in government institutions when suitable facilities are available. This group accounted for about 6 per cent of the total hospital days. Two important new groups have been added to the beneficiaries of the employees' compensation commission in the personnel of the Civil Works Administration and the Works Progress Administration. Members of these groups are entitled to medical relief only for injuries received in performance of duty.

Officers and seamen serving on board the thirty vessels of coast and geodetic survey of the federal government are entitled to medical relief by the Public Health Service. The personnel manning

lighthouse vessels are entitled to marine hospital treatment under regulations similar to those affecting merchant seamen.

Other regular beneficiaries include the officers and crews of the twenty vessels of the bureau of fisheries, detained aliens who are hospitalized for diagnosis and treatment, civilian seamen of the United States Army vessels (engineer corps and transport service), other civilian seamen on United States vessels and cadets on state school ships, seamen on boats of the Mississippi River Commission, lepers, officers and employees of the Public Health Service on full-time field duty, narcotic drug addicts (not in the marine hospitals but confined in special hospitals exclusively for their care), and federal prisoners.

Foreign seamen (that is, seamen from foreign vessels), personnel of the United States Army and Navy, beneficiaries of the United States Veterans' Administration and members of the Civilian Conservation Corps are treated in marine hospitals as pay patients at rates approved annually by the president of the United States.



Book mending goes on in all libraries, mental patients being no more destructive in using books than others.

THERE is a widespread, popular belief that few mental patients are able to read and, furthermore, that if they were given the opportunity they would destroy the books. In addition, people are afraid or at least disinclined to work with the mentally ill.

For seven years I have had the privilege of being supervisor of eighteen institutional libraries of Minnesota. Among these institutions are six hospitals for the mentally ill, with a total average for the last year of 8,971 patients. For the preceding seven years I was hospital librarian in a system of hospitals that included both nervous and mental cases.

These patients make up a large group of hospital occupants all over the world. In the United States the state mental hospitals alone care for almost two-fifths of the entire hospital population, mental or otherwise.

The average length of stay for the patients in a nervous and mental hospital is 1,034 days, or almost three years, a distinct advantage to anyone interested in studying reading as an aid to convalescence.

In our study for the International Library Congress we sent a simple questionnaire to all mental

Based on a paper read before the Hospital Libraries Session of the Second International Library and Bibliographical Congress.

Mental Patients Can Read

By PERRIE JONES

hospitals that are state controlled, 172 in number. We asked for the following information for the year just passed: number of volumes in patients' libraries; circulation for the year; amount spent exclusively for books; how often and how long the library was open; whether it had ward service; who was in charge, and if the person was a trained librarian.

Of the 172 hospitals 129, or 75 per cent, sent replies. Of these 129 hospitals twenty-five reported no libraries, although a few of the twenty-five are served by state traveling libraries. The other 104 gave evidence of some reading service for patients, although in some cases it was slight and almost without records. In some half-dozen states there are well organized systems in the hands of trained librarians. It follows then that mental patients having the opportunity to read constitute about one-fourth of the entire hospital population.

Collections May Need Weeding

I have not said that this number are supplied with reading, but rather "have the opportunity of reading." Being "supplied with reading" suggests that patients have all the books they require, carefully selected with an intimate understanding of the patients' needs and a trained, experienced person with the right kind of personality in charge. This ideal is not at all hopeless; it already has been realized in individual hospitals.

The 104 hospitals reported a total of 198,306 volumes in their libraries. This number is not indicative. While it indicates an average of 1,907 volumes for each hospital, or about one book per patient, many of these books I suspect no one would wish to read. In fact, several who filled out the questionnaire confessed that their collections needed weeding out, that they hoped to improve

And badly need the therapeutic effect of properly selected books. It is all nonsense that they lose or destroy books. In a patients' library mental hospitals have a golden opportunity

the selection of books as soon as times were better, that they had been forced to depend upon gifts, the kind that follow spring housecleaning orgies, or even upon discards from public libraries. We know that things are pretty bad if those in charge admit so much on their own initiative.

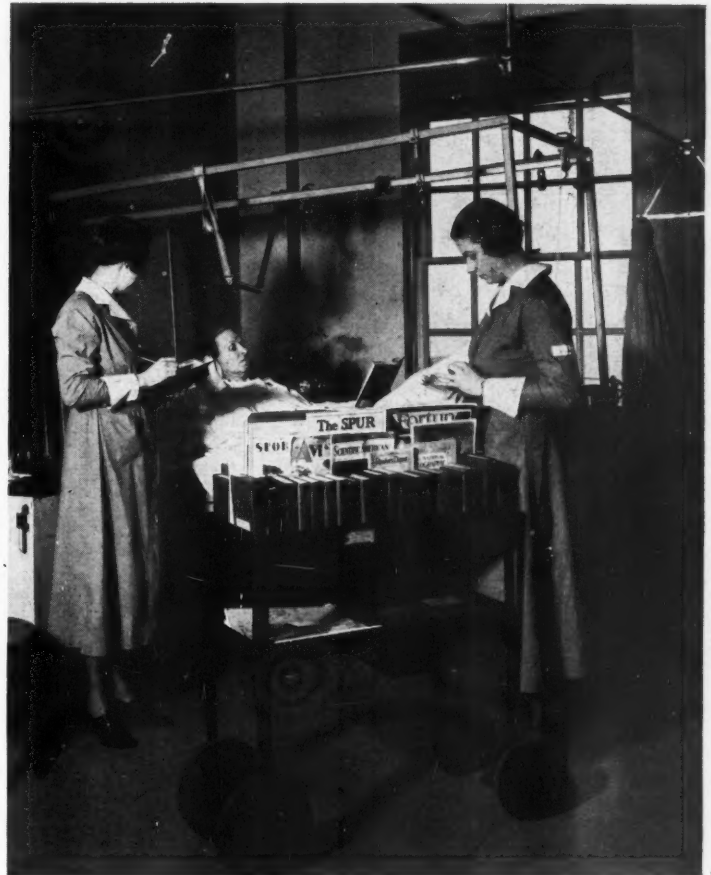
In spite of the hospitals that kept no circulation records, there were figures to show more than 600,000 books had been taken out in 1934, an average of almost three for each patient. If you were to estimate the readers as 25 per cent of the total population, it would mean that each reader had taken out twelve books per year. With inadequate collections for the most part and with two-fifths of the 104 libraries in the hands of a paroled patient or attendant, that there should still be such a desire to read is significant.

In passing compare this average with another mental hospital of the same size, with about 3,000 well chosen volumes, an annual book allowance and a full-time, trained librarian who has the support and cooperation of her medical staff and nurses. This library circulates easily two or three times as much as the average.

Pleasant Atmosphere Is Requirement

Add to that equipment a room that is reasonably pleasant, with chairs and reading tables and some chintz at the windows, open book shelves, clean paint in a soft shade, flowers from the greenhouse, and you have a background that will add to the healing power of books. It helps merely to bring a patient to such a room, whether or not he is ready to read. In such a room I have seen women smile for the first time in weeks simply because they saw something pretty.

It is not altogether a matter of conjecture where the books come from, as we find definite



The ward book truck makes rounds at University Hospitals, Cleveland, and (below) the hospital librarian charges out books fitted to the patients' needs.



budgets for books totaling \$9,600 for the fiscal year, or almost \$100 apiece for the 104 hospitals. As a matter of fact less than half of them reported any book allowance at all, so that the average of those who are actually converted to the necessity of buying books is about \$200.

To complete the picture we must know when the library is open and who is in charge. More than half of the group have daily service every week day and a few on Sundays; almost the same number have service on the wards. Twelve out of the 104 report trained librarians in charge, some in the larger cities coming from public libraries. For those having untrained librarians we find every kind of person in charge: attendants, patients, nurses, occupational therapy aids and directors, stenographers, record clerks, telephone operators, matrons, recreation directors, ushers, welfare and social workers, and one medical librarian at the end of the list.

Viewing the Complete Picture

In looking at the picture as a whole then, we find that of the forty-eight states, thirty-two have libraries in some of their state hospitals for the mentally ill; seven have no libraries and have said so, and nine have said nothing, which leads one to believe that they have very little.

From all the 104 hospitals with more than 200,000 patients there was not one complaint about books lost or destroyed. Realizing that hospital administrators watch waste with hawks' eyes, does it not seem as if the bogey of loss and destruction has been much overstressed.

In addition to sending out the questionnaire, I wrote to a few librarians who have been doing excellent work in private hospitals for mental cases, asking such questions as: Do patients destroy books in your hospital? Do your patients read much? Are they helped by reading?

From one of the leading hospitals of this kind in the whole country came this answer: "We have a patient population of approximately 275. Last year these patients read more than 7,000 books and 4,000 magazines. After the acute phase of the illness is over, all of them use the library. Most of them are of average or superior intelligence and read in their regular lives, so reading in the hospital becomes one of their regular habits as it was at home. I do not lose more than a dozen books a year through physical destruction. Those that seem to be lost are merely misplaced and turn up later.

"Books do get hard wear. I have borrowed hundreds of books from outside libraries for patients and have never had one destroyed or lost. In most cases in which the patients are in a very disturbed

state, they are unable to read and do not want books. Are they helped? Yes, it is a healthful occupation."

Librarians must recognize responsibility to stimulate more service. In a state hospital the head of the state library or commission will be the person to cooperate with the superintendent. If a librarian can be appointed by the state library commission whose sole duties it will be to look after the state hospital, so much the better.

If the hospital is municipally or privately owned, the city public librarian may work out with the hospital superintendent details of service. In each case a close connection must be maintained with a library organization. This will ensure, among other things, the use of accredited methods, a wide selection and knowledge of books and the backing of the service by two permanent public welfare organizations, the hospital and library. It is a mistake, I believe, for the library, even if it could, to take over all the obligations of this service. If there is a division of costs, each organization should try to keep its part of the bargain.

It would help us all, in mental and other hospitals, if some committee could work out standards for recommended number of volumes for hospitals of various sizes, suggestions for the hygienic care of books, washable bindings and contagious technique for books in tuberculosis wards.

Dr. Kurd Schulz of the state library in Thuringia, Germany, after observing hospital libraries at the University of Jena, has suggested that for every 10,000 books circulated there should be a full-time librarian. It is worth while recalling that the circulation for the mental hospital which I mentioned particularly was 11,000. There is one librarian and some patient help.

Special Studies Required

Another point that the committee wishes to encourage is the matter of special studies. There is no hospital better suited for study of the value of reading than a hospital for the mentally ill. The reason for patients' libraries is to aid in convalescence. It seems reasonable, and eminent medical men have gone on record endorsing such service.

Dr. Gordon R. Kamman, an instructor in nervous and mental diseases at the University of Minnesota and a practicing physician, says, "Too few people are aware of the therapeutic possibilities of reading in cases of psychopathic or psychoneurotic patients. Too many casual physicians still look upon the hospital library as a means for bored, idle and restless patients to kill

time. The grateful psychiatrist and neurologist, however, have long since recognized the hospital library as an essential branch of mental rehabilitation. . . ."

What We Don't Know

But do we really know how to proceed in this work? Is there not a whole unexplored field of study relating to the patient and his reaction to the book? For that reason we are beginning to keep specific records of what the patient reads, and comments from the librarian, the patient himself and the doctor.

Do we recognize and study our failures, analyze why certain books have failed with certain patients at certain times? Do we know enough about the patient, what he was reading before he came into the hospital, his normal reading level? Do we know enough about his interests, his worries, his background? In other words, have we yet worked out a method of procedure, or have we even begun a series of studies that will lead to such a recognized procedure? Such beginnings are fragmentary. For the most part we still use the hit-and-miss system.

You may have noticed that I have not used the word "bibliotherapy." I have deliberately avoided

it as I felt that we are not yet sufficiently skilled in our handling of reading as an aid to convalescence to term ourselves bibliotherapists. On this point, Ida M. Cannon, director of social service in Massachusetts General Hospital, said, "There is methodology there for you to work out if you haven't already done it." Not library technique, but a methodology that will include a study of the patient.

Required Combination Is This

I hope you will not think, because of these rather downright remarks, that I underestimate or fail to appreciate the splendid effort that has gone into the work already done. But it seems to me more helpful to contemplate the problems still before us than to take the time to look back upon what has been accomplished.

Such a study as I have mentioned is not impossible, although it will take years of intensive collecting of reading histories, a careful weighing of findings, book evaluating and comparisons of results with a control. That presupposes a large modern hospital, the support and advice of the medical man in charge, an adequate library in the hospital, a trained librarian, time and patience. Even so, I do not despair of such a combination.

Duties for Board Members

By MICHAEL M. DAVIS

1. To know why the organization exists and annually to review why it should.
2. To govern a board or a committee through joint thinking, not by majority vote.
3. To give money or help get it, or both.
4. To face budgets with courage, endowments with doubt, deficits without dismay, and to recover quickly from a surplus.
5. To deal with the professional staff as partners.
6. To keep far enough ahead of the community to be progressive, and close enough to it to be practical.
7. To interpret health work to the public in words of two syllables.
8. To deal with physicians on the assumption that the highest ideals of the profession dominate its every member and to face difficulties with recognition that both doctors and board members are human.
9. To be proud of a tradition but eager to improve it.
10. Always to combine a New England sense of obligation with an Irish sense of humor.

With the Roving Reporter

Tours at Home

- Roving is not necessarily restricted to reporters. It is becoming more and more the habit of hospital superintendents—those, at least, who want to find out what is happening in their own institutions.

Walter Mezger, superintendent at Knickerbocker Hospital, New York, is one of them. Three times a week regularly and without fail he makes rounds. If there is any question about it, try to catch him in his office Mondays, Tuesdays or Thursdays. On Mondays and Thursdays it is general hospital rounds; on Tuesdays it is kitchen rounds.

It is seldom that he travels alone when making general trips through the hospital. Twice each week he is accompanied by the superintendent of nurses and the housekeeper. Sometimes the chief engineer may join the group or perhaps the laundryman. When he covers the kitchen on Tuesdays he always takes with him the dietitian.

Caught breathless after one of these recent excursions, he frankly admitted there was nothing like them. "You always run into something," he confessed.

Good for Trustees

- Having first tried the medicine on himself, Mr. Mezger also has conducted some experiments in roving with his board of trustees. If it is good business for the superintendent to scout about the building a bit, why is it not equally beneficial for the trustee?

Furthermore, why limit him to his own institution? Let him see the world—the hospital world, that is—and arrange for him tours of inspection to other hospitals.

So the gentlemen of the board of Knickerbocker are assigned a certain territory within that hospital which they are requested to cover. On another occasion they cover the same ground in an institution of similar size.

There are four territories in all which are visited so that every man ultimately gets the entire picture. Surely we have here an idea that should lead to new procedures and to bigger and better hospital trustees.

Read as You Enter

- Instead of leaving with a sheet of paper held tightly in their hands, patients at the Conemaugh Valley Memorial Hospital, Johnstown, Pa., receive one as they are admitted and guard it just as closely. It furnishes miscellaneous information they may need to know during their hospital stay, including charges for various services and suggestions by which their visit may be made more pleasant both for themselves and their fellow patients. There is included, even, an estimate of the individual's expenses while he is in the hospital with the following explanation: "Above is an estimate of your expense for your first week in the hospital. This bill is due and payable at the time of admission and must be paid not later than one week from date of admission. You will receive subsequent bills at the beginning of each week during your stay. These bills must be paid within a week from date of issue. Room patients who fail to comply with these rules will be transferred to beds in the wards."

"Any ward patients who are unable to meet these terms must apply at the credit office for special arrangements at the time they are admitted."

"Some items cannot be estimated in advance. The charge for these extras, if there are any not recorded on this week's statement, will appear on your bill at the beginning of the following week."

"The business office is open to receive payments on accounts from 8 a.m. to 9 p.m. If it is inconvenient to pay at the office, notify the supervisor who will have a representative call at your bedside." No chance of any misunderstanding with this down in black and white!

Another feature worth mentioning is the message on the front cover—an excellent good-will builder, according to H. G. Fritz, superintendent. We are quoting it in part:

"Sickness is never welcome, but it is bound to visit everyone at some time in life. We are glad to offer you all the facilities of the Memorial Hospital in the treatment of your present illness. . . ."

"Your doctor is in charge of your case, and your treatment and diet will be under his regulation. Illnesses

which require hospital care often necessitate certain types of treatment and diet with which the patient is not familiar. We trust you will keep this in mind and, should there be any feature which you do not understand, please try to realize that your doctor's orders require these procedures. He will probably be glad to explain them to you. . . .

"Please feel that the entire hospital staff of 250 employees is working for the benefit of the patients. Now that you are one of the patients, you should be receiving the best that these employees can offer in the way of services. The management expects you to receive that quality of service, and should you for any reason not receive it, it will be considered a favor if you will report such failure."

"We hope that your stay as a patient at Memorial Hospital will be a pleasant one on which you will be able to reflect with much satisfaction and credit to the hospital."

Women's Auxiliary Lectured

- Supt. Mary Stone Conklin of Hackinsack Hospital, Hackinsack, N. J., tells of the meetings of her women's auxiliary held monthly in the nurses' home. On several such occasions doctors on the hospital staff have given health talks, each man presenting the subject with which he is identified. Sometimes the audience numbers as many as 200. One talk in particular aroused enthusiasm. Can you guess the title? It was "Home Emergencies."

Way to a Man's Heart

- Every woman knows the answer—many make it their business. So before promising to rove no more for this month at least, let us get a whiff of good cooking in Adeline Wood's kitchens at Mount Sinai in New York. "They told me it simply couldn't be done. Just for that reason I made up my mind to do it," Adeline Wood is heard to remark. In case you do not know what it is all about, and there is no reason why you should, we will explain.

Selected menus at Mount Sinai which are presented to the patients every morning cover dinner and supper for that same day and breakfast the following morning. "How does anyone know a day ahead how he will feel and what he will want to eat twenty-four hours later?" Miss Wood raises the question and answers it by actual accomplishment. Just how she does it remains a secret—something for dietitians to ponder over.

PLANT OPERATION

Conducted by John R. Mannix and R. C. Buerki, M.D.

Going Over the Roof

By A. C. Lamb

ROOF repairing is one of the phases of building maintenance that must be given constant attention. This is particularly true of old buildings. We can expect that a new building, properly constructed, will stand from eight to ten years without much thought being given to roof maintenance, but from then on, it will be a problem that should receive careful and frequent consideration.

Roofs are subject to severe weather conditions which cause expansion and contraction, resulting in cracks. Blisters form and these are injurious to the surface. Flashings pull loose and permit snow, ice and rain to seep into the parapet walls and thence into the rooms below, causing discoloration and falling plaster.

Locating the Leak

One of the difficult problems in roof leaks is to locate the exact spot at which the water is entering. Water frequently runs many feet across the attic before penetrating the ceiling. In cases in which there is no attic or in which the attic is so small a man cannot get into it, the problem is particularly aggravating. A roofing contractor recently explained that his method of locating roof leaks in such instances is to pick a likely spot and start ripping up the roof. He continues until he finds the point at which the water is entering, and then proceeds to put down a new roof to replace the torn up section. Obviously, if he makes a poor guess at the start, the owner may have a bill for a complete new roof.

We check the roof carefully for large or small cracks, blisters, loose flashings and examine particularly the edges of drain sumps and vent stacks. Any place that looks the least bit suspicious is carefully patched.

Two main types of roofs are used in building construction—the flat roof and the hip roof. It is the flat roof that requires constant attention after a few years of service.

Flat roofs are usually of laminated paper or sheet metal. Frequently, the laminated paper is covered with sand and gravel. This sand or gravel covering is for the purpose of dissipating

heat from the sun. It makes the roof heavy and more difficult to patch.

Tar paper makes a cheap, short lasting roof and should not be used except for temporary structures. A good quality felt paper, impregnated with asphalt and laid with asphalt, should always be used when long life is desired. Asphalt should not be used on tar paper or tar on asphalt paper. Tar roofs craze, check and soon go to pieces in cold weather. The tar softens in hot weather and on the slightest inclines runs down to collect in the low spots.

Flashings must be kept tight by calking or remortaring as the original mortar or calking shrinks and falls out. The flashing is probably the most important phase of the flat roof. Snow and ice accumulate during the winter and when the spring thaw starts, water will back up under the flashings and seep through the parapet walls unless the flashings are kept tight.

"The Great Destroyer"

The parapet walls themselves should be lined on the inner surface with a nonabsorbing brick or other construction material that does not absorb moisture or they should be treated with an asphalt preparation to prevent moisture absorption in case porous materials are used for backing up the face brick. A parapet wall that absorbs moisture is a constant source of trouble. No matter how tight the roof may be, moisture will eventually get into the building through the parapet wall if it is constructed of porous material and if it has not been treated to make it weatherproof.

Moisture is by far the worst enemy of buildings and is respected by the engineering fraternity as "the great destroyer." Lack of moisture is the main reason for the extremely long life of buildings in Egypt and our Southwest. This, added to the lack of frost, permits building with cheaper materials that outlast anything built in localities where there are both moisture and frost to combat.

Cracks that occur in roofs because of expansion and contraction resulting from changes in temperature can be

repaired by filling the cracks with a plastic compound composed of asphalt and asbestos fiber. After the crack is filled with this material it should be covered with a fabric similar to burlap, which has been treated with asphalt. Small cracks should be covered with a strip of this fabric at least 6 inches wide, or wider in proportion to the width of the crack. The plastic material should be spread at least 3 inches back from the edges of the crack and the fabric pressed down on the plastic material.

The final operation consists of painting over the fabric with a liquid coating containing asphalt, which is about the consistency of thick paint. This will form a patch that is absolutely weatherproof and will give with the expansion and contraction of the roof.

Treating Roof Blisters

Another source of leaks on roofs are blisters. These blisters sometimes fill with gas and often with water and, in some cases, cover several square yards of roof. When the blisters contain water, it is due to the absorption of moisture that is drawn up to the surface of the subroof by the summer sun and accumulates under the paper.

In the cheaper double slab roofs that are filled with cinders or other light material, gases accumulate and cause large blisters; these, if not repaired, will soon ruin a roof. Blisters should be cut open by slitting with a knife. The heavy plastic material used for cracks is then spread inside the blister under the roofing paper and the paper is pressed down into the plastic. The slit is then treated as suggested previously for cracks, being covered with the same fabric and a topping material consisting of asphalt having the consistency of thick paint.

Flashings are frequently made of galvanized metal. After a few years, these rust away and become perforated and bent from the action of frost and ice. The metal pulls out of the joint in the parapet wall, which permits water to run down behind the flashing and thence under the roof material. The only remedy for a situation of this kind is to replace the flashing. The roofing paper can be carefully lifted, the flashing metal inserted beneath and tightly calked into the parapet joint, and the roofing paper then pressed against the flashing. The paper should be thoroughly coated with asphalt so there will be a good bond between the roofing paper and the flashing.

Flashings made of galvanized metal should be painted to prevent rusting. Whenever possible, either copper or lead should be used for flashing. This is more expensive but more lasting. Both copper and lead flashings will pull away from parapet walls and

must be frequently inspected to ensure their being refastened into the joint before bad leaks develop.

Parapet walls must be maintained in a weatherproof condition by pointing, painting and calking. Occasionally, we find that the coping or top covering of the parapet wall is admitting moisture. In cases in which the leaking coping is of tile or stone, either natural or artificial, the coping should be removed, a covering of copper or roofing paper put over the parapet and the coping replaced.

The ideal method of sealing a parapet wall is to cover the top of the wall with copper wide enough that the edges may be bent down and forced into the first joint the same way that the flashing at the roof line is inserted in the joint. The coping is then placed on top of this copper shell. Such copings are expensive but permanent. When funds are not sufficient to permit the use of copper or lead the parapets can be sealed satisfactorily for a number of years, with a heavy roofing paper. Both the exterior and the interior faces of the parapets should be thoroughly pointed at all times to prevent the absorption of moisture, as this point of attack is as vital as the roof itself.

Hints on Hip Roof Repairs

The insides of all parapets may be treated by painting or spraying a liquid asphalt material on to the brick, terra cotta or concrete from the flashing line to the coping. This effectively waterproofs for a period of five years.

Hip roofs are frequently treated with tile, slate, copper, lead or concrete in slabs. A roof of this type is almost as long-lived as the building.

Occasionally the wind in a severe storm will blow some of the tile loose. This necessitates straightening out the tile and in some cases replacing them when they are broken. In one instance, it was found necessary to repair a tile roof owing to the fault of the contractor who originally constructed the roof. The subroof was not properly constructed. After fifteen years in service, it deteriorated to the point at which it was necessary to remove all the tile and build an entirely new subroof. In this case, the subroof was constructed of matched lumber on wood rafters, the matched lumber being covered with two layers of tar paper. The tar paper cracked and checked until water seeped through into the attic whenever it was blowing hard enough to drive the rain up under the tile. The tile was removed and a new subroof built by covering the matched wood roof boards with three coats of asphalt paper, cemented down with liquid asphalt. The tile was then replaced, using copper nails and increasing the lap of the tile. Originally, the roof tile had not been lapped suf-

ficiently to prevent water blowing under the open ends. This necessitated buying additional tile to make up for the extra lapping. There are other buildings that are eighteen and twenty years old on which the tile has never been touched and they are as tight today as they were when constructed.

Slate roofs come in the same division and seldom need any attention other than a periodic check-up. When slate roofs do need repairing, the work

should be left to skilled tradesmen who are thoroughly familiar with the construction of slate roofs. Slate is difficult to install because of its brittle quality and, therefore, requires a capable man to make any repairs. A man who does not understand the work will do more damage than good. However, repairs are so infrequently necessary that the slate roof is virtually no problem at all from the standpoint of maintenance.



Design for Small Laboratory

By Laurence H. Mayers, M.D.

COMPACTNESS, coordination of equipment into the most efficient units and careful attention to all details that aid in saving time or effort on the part of laboratory workers are the features sought in the new laboratory recently installed in my office. Since this laboratory is equipped to do practically every type of test encountered in small hospitals, details about it could be readily adapted in hospital planning.

Before designing this laboratory an elaborate study was made of space requirements and location of equipment. This study was supplemented by long observation and experience in directing laboratory work. Special attention was given time-saving arrangements and to cleanliness—a vital matter in accurate laboratory work.

The laboratory consists of one large room, 26 by 10 feet, and a small room,

4 feet 8 inches by 7 feet. The latter is little more than a closet and one side is taken up by a window, across which is a work table. This small room is used exclusively for bacteriologic work and for the reference library. Its equipment includes, in addition to the table in front of the window, a built-in work bench to the left of the window over which there are a gas outlet, an air outlet and a double electric plug. On the third wall are a cabinet and several shelves, one of them for books. The radiator in this room, as in the main laboratory, is low and narrow and so designed that the heat is reflected against the window, preventing hot air from rising in the worker's face.

In addition to the bacteriologic work in the small room there are spaces arranged for urinalysis, blood counting, serology, making up

Safety

AT THE CROSS-ROADS!

WHY GRADE SEPARATIONS? The Federal Government alone has spent a quarter of a billion dollars in one year to prevent the 5% of motor accidents that occur at grade crossings—and this is just a beginning. Yet no accident ever occurred at a grade crossing that was not due to human error. Some 1300 people who fail to "Stop! Look! Listen!" are killed each year; and will only be saved, in spite of themselves, at a scheduled cost of more than a billion dollars.



SAFETY WITH SAFTIFLASKS

WITH SAFTIFLASKS "grade-crossings"—the chances for human error—are prevented by delicate, all-embracing tests.

Of course, skilled hands, masters of intricate equipment and apparatus, guided by minds trained for years in their own particular branch of science, are responsible for each exacting step in the preparation of dextrose and other solutions in Saftiflasks.

But, *despite* exacting care in production—no Saftiflask can reach your hands until the lot of which it is a part has been *proven safe* by rigid chemical, bacteriological and physiological tests put on by testing experts entirely divorced from the production group.

Then, as a final precaution—to give you visible assurance that the solution has not been accidentally exposed to contamination—every Saftiflask is doubly safety-sealed;

by vacuum, and by an easily removed viscous seal.

And what do you pay for this assurance that every possible care has been taken to make your dextrose solutions safe? Actually, on the basis of direct costs alone, these ready-to-use solutions in Saftiflasks are less costly than those prepared from concentrated ampules. And, when all of the indirect costs are carefully evaluated, they will be found to be no more costly than those prepared from raw chemicals.

Saftiflasks are available from strategically located distributors throughout the country. They are manufactured by The Cutter Laboratories (U.S. Gov't. License No. 8) of Berkeley, California and 111 No. Canal Street, Chicago. Member of Hospital Exhibitors Association.

Saftiflasks



40 years of experience
in production of products
for intravenous injection



The refrigerator was especially designed for this laboratory. The usual ice cube element has been taken out and the cooling coils run down through the center, thus giving more storage space. They also cool a pipe so that cold filtered water is always available.

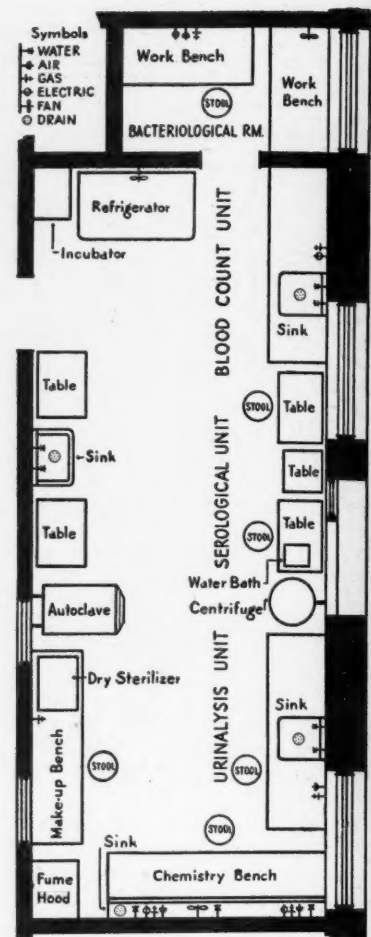


This chemistry bench has many unusual features, such as the copper-lined trough at the back, the simple siphoning arrangement for drawing some of the most frequently used chemicals and reagents, and the small rack for holding the volumetric pipettes.

ampules, blood chemistry, making up solutions and dishwashing. In another room, which can be readily darkened, is equipment for darkfield examinations. Seven persons can work in this laboratory at one time without the annoyance of confusion or interference.

The large room has tables, benches, shelves, cabinets and sinks conveniently disposed along the walls, and there are gas, air and electric outlets at intervals.

The chemistry bench and fume hood cover the entire south wall with a set



Plan of a compact laboratory that can house seven workers, if necessary. Each unit is as nearly complete in itself as possible. Plan reproduced from Medical Economics.

of six shelves above. At the extreme back of this bench is a copper-lined trough, 5½ inches wide. The edge of the trough is level with the top of the bench, but the trough slants at the bottom from 4 inches in depth at one end to 7 inches at the other. It will take care of the flow from three water taps, and also provides a sink into which strong acids and alkalis may be emptied. The value of three water taps over the chemistry bench is obvious to the laboratory man. They also give added convenience for the placing of water suction pumps. Running cold water is easily within reach.

This bench also has two air, two gas and four electric outlets. The shelves above give ample room for the reagents and chemicals in frequent use, and the fine scales are close by and the fume hood adjacent. The lower part of the hood forms a comparatively dark compartment and is used for storing solutions and supplies that must be kept away from light.



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BECAUSE of its beauty, economy and cleanliness, Sealex Linoleum is recognized as the ideal hospital floor for all areas. The Sealex Floor above shows how effectively this versatile material can be used in special rooms.

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Linoleum provides a charming background.

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Floors and Walls

A feature of the chemistry bench is the burettes used in the accurate measurement of various solutions employed in the blood chemistry routine. From three of these burettes glass tubing runs back into the bottles on the shelves above. This simple siphon method facilitates refilling the burettes. The small rack, seen at the right of them, is used to hold volumetric pipettes, and is so arranged that they may drain after washing.

Following around the wall from the right of the chemistry bench, one sees a gas-heated dry sterilizer, a cupboard and the copper autoclave, for which steam is provided from a gas-heated boiler. The sink next to it is used for washing glassware and the shelves adjacent to the sink are so fashioned that graduated cylinders, funnels, flasks and such things may be up-ended and hung to drain into the sink.

Farther along appears the bacteriological incubator and next to it, the electric refrigerator, built especially for this laboratory. The motor and evaporator are in the bottom of the

box, and the usual ice cube unit within is absent. The cooling coils run down through the center, and also cool the pipe that leads to the tap outside the box, so that cold, filtered water is always available. The shelves within the refrigerator are arranged to accommodate vaccines and antigens.

There are two electric fans in this room, placed high to give complete circulation. All fixtures, except the sterilizer and autoclave, are chromium plated. The floor is covered with waxed rubber tile and the benches are surfaced with an acid and heat-resisting asbestos composition. The drawers for storing corks have partitions running to the top of the drawer so the corks will not be jolted into the wrong section when the drawer is opened or closed.

The laboratory has already proved itself. At the end of five months nothing has been found lacking while the disposition of the fittings and equipment has expedited the work. For the purposes sought, the laboratory is complete, convenient, efficient and comfortable.

The simplest and least expensive type of in-and-out indicating system is a board with names down the left side and sliding blocks over "in" and "out" to give this information. This mechanism can be seen only by those who personally inspect the board. This handicap may be overcome by an electrical in-and-out board that illuminates the doctor's name, not only at the door but also in the telephone switchboard room. These systems are highly efficient and although the original cost is higher, the cost of upkeep is low. This is especially the case if the unit is sufficiently flexible for the doctor to turn it on and off in various parts of the building.

In the University of Chicago Clinics, a private system of house telephone or other signals is used between the main kitchen and the ward serving kitchen. This is also used on the dumb-waiter. Any cafeteria has a demand for a simple signaling system between its serving counters and its kitchen.

Watchman's service is widely used in the larger hospitals. Almost always there is some indicating or recording mechanism so that the watchman is able to prove easily and conclusively that he made his rounds punctually.

The simplest is the watchman's clock case containing a sturdy, well protected, spring wound clock carrying a paper tape or disk. At each station the watchman inserts a key, which is firmly attached to that station. Each station key bears a different marking, usually a figure, and when inserted in the clock gives an embossed record of the station and the time the key was used.

A system considerably more elaborate requires the watchman, by means of a push button or key, to close an electric circuit on his itinerary. The electric record gives the same information as the watchman's clock, the difference being that it is inaccessible to the watchman.

A more flexible system is one that may be connected with any dial telephone system whether privately owned or not. Under such circumstances the watchman dials a predetermined number on each telephone on his route. This gives a written graphic record of the telephone from which he called, as well as the time.

Fire alarm systems are best if planned in close cooperation with the local fire department. To be of maximum value any system should have a direct wire to the nearest fire station.

Direct connection may be made with private police wires. Since this system is frequently independent of the utility telephone system, its value is enhanced. If the receiver of a private police line telephone is knocked off, the police will investigate at once, unless they obtain a satisfactory explanation of the occurrence over the private or utility exchange system.

Ears and Eyes of the Hospital

By John E. Gorrell, M.D.

Signaling apparatus may be of numerous types and may employ various methods of hospital intercommunication.

SIGNALS may announce by one or a combination of methods.

Annunciators usually operate by moving a pointer, dropping a flag, or moving a part to show a name, number or other signal.

Illuminated annunciators may have no moving parts. This is the simplest and most inexpensive type. A ground glass sheet with figures or names painted on the inner surface becomes illuminated when the light is on. The signal is clear and rarely confused, especially in poorly lighted rooms and corridors. If a great many names or numbers are to appear on this type of annunciator and especially if used for general paging throughout an institution, the expense of cable and wiring may be worthy of serious study.

A common bell may be used but the annoyance usually suggests that a buzzer be used. There are low cost noisy buzzers which render poor service and good buzzers with low volume,

high pitch and a nonirritating tone. The life of the latter is long, the pitch and volume are adjustable and the cost from \$1 to \$3.

A desirable feature rarely utilized on buzzer plans is the "call-back." If the administrator calls for the book-keeper or the secretary by buzzer, ordinarily he has no way of knowing if the person called was reached. Many inexpensive "call-back" features are possible. The simplest is a return circuit, which needs only an additional wire. Another is a small annunciator or light that stays on until the signal is disconnected.

Elaborate mechanism is sometimes purchased for a task which skillfully planned buzzers and annunciators could accomplish. Any signal or communication system is no better than the skill with which its use is planned.

For paging or other signal purposes, the sound producing mechanism may be bells, buzzers, gongs or telegraph sounders. An 8-inch bell in the engine room and a low toned buzzer in the lobby easily can be made to operate from the same system.

Why stock tickers are not used more for other businesses and especially for hospitals is difficult to say. The equipment cannot be purchased outright, although it may be leased from telegraph companies. Some used equipment is available in larger centers.

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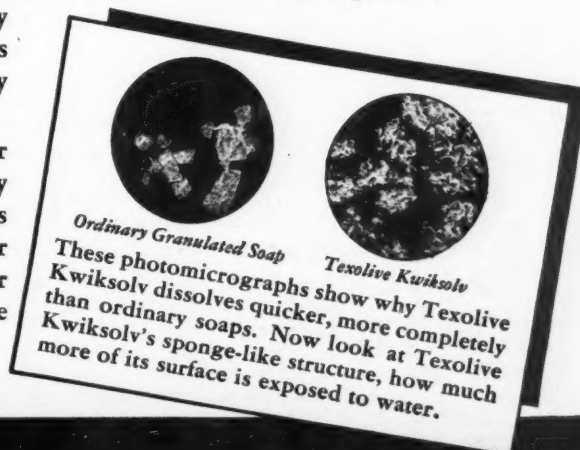
Made by special formula, with coconut oil added for extra sudsing, Texolive Kwiksolv is perfect for all cold water washing. It is *pure* soap made from low titre oils . . . *safe* enough for use on the very finest woolsens.

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dissolving" form . . . tiny, *sponge-like* particles that dissolve instantly and completely, giving thick, rich suds even in cold water . . . Texolive Kwiksolv eliminates costly waste. It saves time, labor and money and the initial cost is no greater than many less-efficient brands.

This year make your blankets last longer by washing them with this *outstanding* cold water soap! Next time your C.P.P. man calls, be

sure to ask him about Texolive Kwiksolv. Or, write direct to Colgate-Palmolive-Peet Co., 105 Hudson Street, Jersey City, New Jersey. Either way there's no cost—no obligation.



TEXOLIVE KWIKSOLV

A PRODUCT OF COLGATE-PALMOLIVE-PEET CO.

Initial cost of any paging or signal system will vary according to its size, the care used in purchasing it, the design and type of system, the skill with which it was laid out and the amount of it built in the hospital shops.

The cost per year, both of the service maintenance and replacement, should not exceed 5 per cent of the original investment. Gongs and loudspeakers have almost indefinite life. Small electric light bulbs should average from 1,000 to 2,000 burnings before replacement is needed, and if the system is intelligently planned, bulbs should be available for a few cents each.

Since all the systems are electrical, the mechanism even for an extensive system need not be large. By the use of relays the feeblest impulse can be used to energize any number of units

or groups of units. If the original transmitting mechanism contains the maximum actual number of combinations, there is no reason why it should be outgrown. Future expansion and capacity are easily and simply cared for.

When wires must cover a great distance, whether in one building or between groups of buildings, a certain loss in the strength of the current is inevitable. On some systems the use of relays will compensate satisfactorily.

Frequently the purchase of paging equipment is influenced by the statement that a given system has one wire or many. The administration may conclude that with less wires, the construction will be simpler. Almost always the reverse is true, because a great number of wires requires less choice in transmitting or paging units.

Pressure steam heat is used as the method of heating by forty-five institutions, subatmospheric steam by 16 and hot water by 6. Three institutions use more than one system, using subatmospheric, for example, and hot water in different parts of the buildings.

Administrators differed widely in regard to which system they thought best. High pressure steam with reducing apparatus and subatmospheric were mentioned with about equal frequency. Hot water heat was mentioned occasionally. Forty-one of the 66 reporting hospitals stated that they had a trained licensed engineer in charge of the power house, but in only 9 institutions did he devote his entire time to engineering work. In the others he combined it with janitorial, maintenance, repair, pipe fitting, laundry supervision, and in one instance with "ward duties." In another hospital the engineer is also a night watchman.

Purchasing for the power plant is done most often by the superintendent. Twenty-seven hospitals reported this as falling within his jurisdiction. In 16 institutions the board of directors or committee thereof make such purchases. In 4 more the superintendent and board do the buying jointly. The engineer makes such purchases in 7 hospitals, and in 2 institutions power plant equipment is purchased through the architect's office. Various departments of local government make such purchases in three hospitals.

Electricity is manufactured by only 10 of the 66 reporting hospitals but 5 others are seriously considering making their own instead of purchasing it.

Ventilation in 35 of the hospitals is by open windows only, 30 use suction fans and 2 provide filtered air.

Power Behind the Plant

A SURVEY of practices in hospital power plants recently made by *The HOSPITAL YEARBOOK* revealed interesting variation in heating problems and methods among the hospitals. In order to make a rough division between the northern and southern parts of the United States, the country was divided into two districts by the fortieth parallel, which runs east and west approximately from Washington, D. C., on the Atlantic Coast, to Sacramento on the West. Fifty-three of the reporting hospitals lie to the north of this line and thirteen of them south of it.

In the fifty-three Northern hospitals, nine use hard coal for heating, twenty-nine use soft coal, one uses gas and eleven use oil. Three hospitals failed to report.

For the hospitals using hard coal the number of tons varies from 4 to 22 with 6 to 10 tons as an average including all but the exceedingly high institution and the exceedingly low one.

For soft coal users, the variation was even greater, from 4 to 38 tons per bed. There were 6 hospitals using 4 tons per bed annually; 10 use from 6 to 9 tons per bed annually; 8 use from 10 to 15 tons annually and 4 use more than 15 tons.

One 88-bed hospital in Utah uses gas for heating and spends a total of \$784 per year. The number of gallons of oil used for heating per bed varies from 308 to 2,000. The hospital using only 308 gallons is a contagious disease hospital in Massachusetts, probably not using the full capacity during all of the heating season. Of the other six hospitals from which the average

Survey reveals wide variation in types of fuel used and heating problems of 66 hospitals

number of gallons of oil per bed can be computed, 5 use between 1,200 and 2,000 gallons.

Stokers are used by ten of the hospitals. All of them were satisfied.

A smaller body of data is available for the hospitals south of the fortieth parallel. Only 13 sent in usable data. Of these 12 used hard coal but failed to state the amount used. Eight used soft coal at a rate of 2 to 9 tons per bed per year; 2 used gas and 1 used oil. Seven of the 9 coal users have automatic stokers and all report them to be satisfactory. One Florida hospital reported that it has no heating plant and uses oil for heating water.

Present hospital power plants are fairly old, the oldest being one installed in 1896. There were 5 others installed between 1900-10, 8 between 1911-20, 27 in the decade between 1921-30 and 23 since 1930. Moreover, at the time the questionnaire was circulated early in 1937, 10 hospitals reported they were planning to make further changes in their power plants. Two are planning to install stokers, 4 are planning to purchase oil burners, either to supplement existing equipment or in place of it. New heating systems are contemplated by 3 hospitals, new boilers by 4 institutions and new generators by 1 hospital.

Hospital Heating in England

The comparative merits of surface radiation and imbedded panels as a method of heating hospitals is receiving considerable attention in England at the present time. A committee appointed by the minister of health recently reported that the construction cost of panel heating was approximately one-third larger than that of radiators and that evidence was lacking as to the operating costs of heating hospitals by the two methods. The committee did report, however, that in office buildings of similar construction, a test showed that the steam consumed in maintaining a rise of temperature of 30° F. in a building of 100,000 cubic feet was 170 pounds per hour by radiators and 88 pounds per hour for imbedded panels. The committee hesitated to accept these figures as a guide for hospital wards because of the high degree of ventilation required in hospitals.

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Fixtures available for hospitals is the Surgeon's Acid-Resisting Enameled Wash-up Sink. It is equipped with an elbow operated supply fitting to regulate the flow and temperature of the water.

Another special fixture on display will be a modern, attractive One-Piece Closet specially equipped with bedpan lugs and a drain pocket. Information about the complete line of "Standard" Plumbing Fixtures can be obtained at the convention booth or by writing to Hospital Fixture Dept., Standard Sanitary Mfg. Company, Pittsburgh, Penna.

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PITTSBURGH, PA.

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HOUSEKEEPING

The Golden Rule in Housekeeping

By Alice M. Eldridge

THE relationship of the executive housekeeper to her employees begins with the application card. Selecting the new employee is just as significant as selecting furniture or friends. If you are careful and use good judgment usually the result is good.

The new employee should be considered from many standpoints. His approach, his appearance, apparent intelligence and attitude in general. How did he fill out his application card? Was he careless in answering questions? Did he answer all the questions? If he is careless in these matters it is fair to assume he will be the same in his work. This does not always hold true, but it can be applied to the average individual.

It is well to show the employee the section in which he will work and the amount of work he is expected to cover. Tell him of the hours, pay, time off, and watch the reaction. If this is satisfactory we may assume that he will have the right attitude toward his work. We should try mentally to picture this person in the particular job to be sure he is qualified.

Select persons of the same nationality as far as possible. This is not so important or marked in California

as it is in the South and some parts of the East, but it promotes harmony if this point is taken into consideration.

To do good work people must be happy in their work and it is the executive housekeeper's job to keep her workers happy. She must promote friendly rivalry and provide the necessary stimulus. She must be interested in their personal problems. She must have infinite patience. The new employee is untrained and unskilled, which calls for constant teaching and training. Sometimes we have men and women who have been well trained in some other line of work but they must be taught just the same as the person who has had no education at all. True, they learn more rapidly and bring more to their work, but the executive housekeeper's job is still one of teaching.

"What is there to know about janitorial work that anyone cannot do?" We very often hear this question and the answer—"Oh you don't have to know much to be a janitor, I'm sure I could do it." Let us consider this.

Did you ever stop to think what damage an untrained man or maid can do to your fine floors and furnish-

ings? You spend thousands of dollars on plumbing fixtures and an untrained worker ruins them in a week's time. Did you ever see a washbasin, clinic sink or bathtub with the glazing gone? Who did it? The untrained worker with the wrong material. Very often a strong acid is used because it cleans quickly, but it ruins the fixture. What about the proper care of linoleum and hard wood floors? Do you know why paint jobs don't hold up and housekeeping costs are high? It is because the janitor is untrained. You spend millions for beautiful buildings and then hire the cheapest help you can find to take care of them.

We feel that janitorial training is so important that a school has been established at Fairmont Hospital, San Leandro, Calif., to teach men janitorial work. This class is under the direction of the Oakland School Department with John Mahoney as teacher, and there is so much to learn that they have class twice a week for the entire school year.

The executive housekeeper should encourage her employees to bring in suggestions for the good of the institution. They are in close contact with the ward supervisor, floor nurse, patient and visitor and often can make valuable suggestions. They hear criticisms of service that the department heads or doctors never hear and many times a situation is saved because some employee in a minor position kept his eyes and ears open and did his talking to the department head.

In the matter of accidents the executive housekeeper must always be alert for ladders that are dangerous; safety belts that aren't safe; standing on chairs to dust high places or standing on the edge of a bathtub to change a light globe; lifting improperly or hands cut on a razor blade left in a towel. These are just a few of the things that cause us grief.

If an employee is hurt we must have him taken care of at once and the proper report made. Failing to report an accident often causes serious trouble later on and should be discouraged.

The executive housekeeper should strive to provide modern working equipment. A carpenter cannot do good

One of the miniature rooms on display at the National Executive Housekeepers Association meeting in Cleveland. Two other model rooms appear on page 90.



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work with poor tools. Why should we expect otherwise from our workers? We will get more and better work if we provide a handy, well equipped janitorial working base, than we will if we allow them to have any kind of a closet, kept in a haphazard way in some dark corner. The executive housekeeper should demand that the janitors' room be clean and orderly. If their working base is untidy their work is apt to be so also.

We should teach the proper use of brooms, brushes, polishing machines and vacuum cleaners. Each man should have his own set of brushes and brooms, in order that he may be held responsible for their care.

The executive housekeeper should see that her staff comes on duty neat and clean. It is most objectionable to patients to have a porter or maid working near them who has the least bit of body odor. It is sometimes necessary to send them off the floor to freshen up, but if the person is a repeated offender the executive housekeeper should call him to the office and warn him that it cannot be tolerated.

The matter of cleanliness of dress is another thing that is important. A uniform of washable material is desirable for there is then no excuse for being dirty. These should be serviceable and durable allowing plenty of room so that the worker may work freely. It is easy for the average worker to become careless and untidy, therefore the executive housekeeper must set a standard for her people and insist that that standard be maintained.

The monthly meeting is most desirable in order to enable the executive housekeeper to take up and discuss all departmental matters of importance. It gives her a chance to bring before her people matters of policy and to caution, guide and direct them. These meetings can be made a good safety valve and also educational and inspirational.

Impartiality Essential

The executive housekeeper must be absolutely just and impartial towards all her employees. It is very much like a jig-saw puzzle. She must change the person around until she finds where he fits; then leave him there in order to complete the puzzle. Many of the workers in this field of work do not adjust easily and do much better if left in one place after being trained for that place.

It should not make any difference to the executive housekeeper whether she personally likes a worker or not as long as he is doing good work for the hospital. And above all she must treat them all alike. What is good for one is good for all and she must not do for one what she cannot do for all.

In summing this all up it is simply a matter of the golden rule: "Treat them as you would like to be treated."

Windows Clear and Clean

By Mary Blount Anderson

IN NO building are windows more important than in the hospital. They take away the feeling of confinement, they promote cheerfulness and contentment, but to do this they must be clear and clean. The housekeeper's problem is how can this be done with the greatest degree of efficiency and satisfaction.

First we shall consider some of the factors in the approach to window washing in the hospital. For the window washers' schedule, the windows have been listed into three groups—those in offices, laboratories and dormitories, those in dietary, obstetric and operating rooms and those in the nursing department proper.

The windows in the first group are washed regularly as scheduled and with little variation in time requirement. Those in the offices are washed once each week, on Mondays; those in the laboratories, twice each month, and in the dormitories and clinic, once each month. In the second group, the dietary, operating rooms and obstetric divisions, the windows are washed once each week.

Conduct in Patients' Rooms

It is the windows in group three that require some supervision other than washing. The men are taught to regard the patients' comfort above all else, therefore they must enter the room quietly and do their work deftly and quickly, being careful to avoid creating draughts. The washer must be clean, both in body and attire. On the days that windows are to be washed on a nursing floor, the supervisor on that floor is notified. She in turn, informs the housekeeper if there are patients who should not be disturbed. If the patient is quite sick, or perhaps temperamental, but still it is permissible to wash the windows, the men will complete that window or windows in one operation instead of team work, one in and one out.

As far as possible, we try to follow the schedule and complete each unit of window washing for the reason that psychologically many persons are affected by the appearance of windows—cheerful when they are clear and clean—downcast and forsaken when they are dirty and translucent.

One month's work as completed by the wall and window washers at Provident Hospital includes the washing of 722 windows, 540 doors, 277 transoms and 472 electric light shades. A scheduled number of hours each week is allotted for washing walls in the hospital and clinic.

Two men are responsible for this

Shining windows take away the feeling of confinement and promote cheerfulness among our hospital patients.

unit of work. They work by schedule and a daily record is kept to prove the advantage of teamwork. Take, for example, the month of April, in which there were 26 working days. The record shows there were 923 windows washed and 112½ hours of work done in washing walls, transoms and electric light shades. The plan is to stagger the window washing, with some washed on a weekly schedule, some bimonthly and a few basement and storeroom windows only once each quarter.

Seasonal changes frequently affect this unit of the housekeeping plan. When the screens are out in the early spring, the men speed up their work to an average cost of from 5 to 8 cents per window. The cost increases to from 8 to 10 cents per window when the screens are in, and in winter a further cost is noted. In the coldest weather no window washing is done, the men spending their time in washing walls and woodwork. Costs just mentioned are based on the regular monthly salary of these two employees.

Cost of Supplies Kept Low

The cost of supplies for this unit of work has been kept extremely low. One chamois skin is made to last from four to six weeks. Squeegee rubbers are replaced about once every two years and the cleansing agent used averages about 50 cents per month. Sponges are used at the rate of one each month for each person. This represents about 4½ mills per window for materials.

The window washers' belts are checked in the department and as occasion requires are sent to the American Window and Safety Device Company for checking and repairs.

The comfort and welfare of the patients in our hospital are our first consideration and emphasis is laid upon quietness in working, observation of various reactions as the worker goes about his duties and willingness to serve in a kind and intelligent manner.*

*From a paper delivered before the Tri-State Hospital Association convention, Chicago, May, 1937.

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THE HOUSEKEEPER'S CORNER

• It is the preliminary work that makes an organization function efficiently. Recognizing its value, too, in promoting enthusiasm, Mrs. Adele B. Frey, president of the National Executive Housekeepers Association, has been forehanded in naming committee chairmen to direct activities of the various departments during the coming year. Hospital members appointed include Mrs. Alta LaBelle, executive housekeeper at Michael Reese Hospital, Chicago, co-chairman with Mrs. Grace Brigham, Providence, R. I., of the program and lecture committee; Alice Eldridge, housekeeper at Fairmont Hospital, San Leandro, Calif., chairman of hospital research, and Lillian Jacques, Newton Hospital, Newton Lower Falls, Mass., a member of the same committee, and Mrs. Doris Dungan, West Jersey Homeopathic Hospital, Camden, N. J., chairman of the welfare committee. Mrs. LaBelle also is a member of the committee on publicity and radio.

• Active steps are being taken by the Los Angeles chapter of the National Executive Housekeepers Association to enable its members to acquire a wider knowledge of mutual problems by carrying on practical research for the advancement of housekeeping technique. In addition to the study classes, lectures are being given by outstanding people in their particular fields. These subjects include personnel management; interior decoration; housekeeping budgets; how to judge, train and employ help; purchase of linens and fabrics; conferences con-

ducted by the board of education; educational films of women's work; fire prevention; labor laws, and many other subjects. Another activity of this chapter is the Clearing House Bureau, organized to assist unemployed members in securing suitable positions.

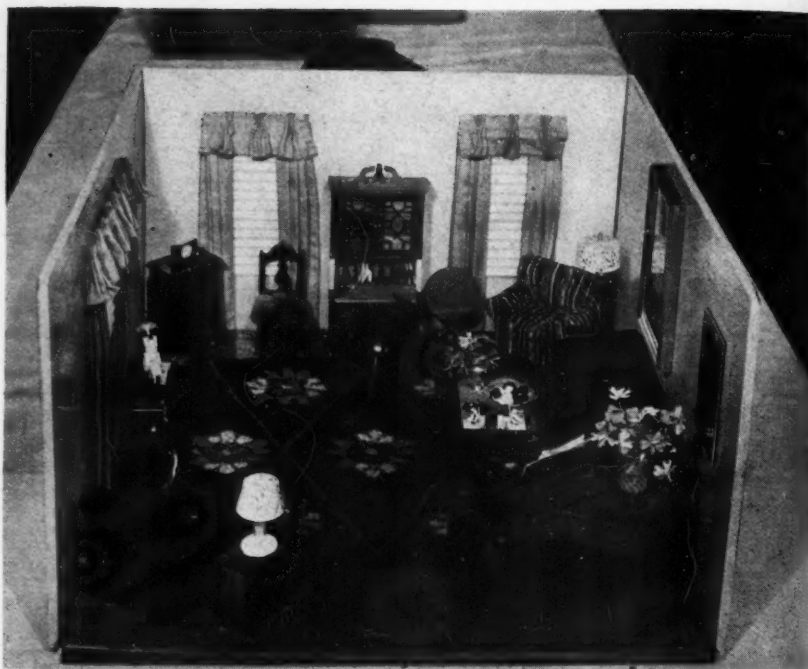
• The hotel manager's viewpoint on housekeeping will be presented by the manager of a group of Minneapolis hotels at the next meeting of the

Minnesota chapter on September 7. The meeting will be at Midway Hospital, St. Paul, with Mrs. Clara Thauwald, executive housekeeper, as hostess.

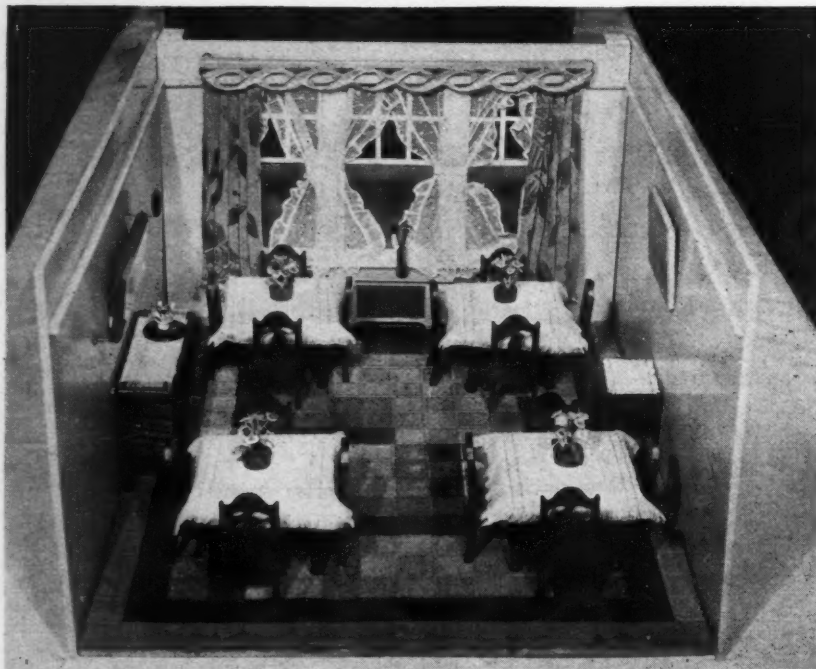
• The Chicago chapter of the NEHA is justly proud of the interest hospital superintendents have shown in their *Commentator*, edited by Mrs. Alta LaBelle, who merits praise for an interesting magazine. One superintendent has written regretting that his housekeeper is not progressive enough to join the organization and that he is replacing her. The inference was that he wants a housekeeper who can see the value of NEHA training courses and exchange of ideas. Meetings of the Chicago chapter will be resumed on September 2 and the next issue of *Commentator* will be distributed then.

• After trials with many materials, Mrs. Mildred Page, housekeeper at Henrotin Hospital, Chicago, has found that boat drill makes the most satisfactory stupe wringers. The material is moderate in price, is a yard wide and cuts to advantage, while the blue line at the selvage makes an attractive finish.

• Even with the utmost care on the part of attending nurses, small instruments used in the operating room have an uncanny way of turning up among the linen in the laundry chute. To eliminate this loss, the housekeeper of one large Midwestern hospital has detailed one maid to shake each piece of linen that comes from the operating room before it is sent to the laundry.



At the NEHA booth in Atlantic City during the A. H. A. convention this and other projects will be shown. This room was arranged by Catherine Pieleke of University Hospital, Philadelphia.



This inviting miniature staff dining room is the work of Eleanor King of the Willow Crest Convalescent Home, Willow Crest, Pa.

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FOOD SERVICE

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Food for the Hospital Party

By Adeline Wood

THERE is an erroneous idea that the responsibilities and work of the dietitian are routine and monotonous. Any work, well organized, is routine, but it need not necessarily be monotonous. Variety is or should be one of the outstanding factors of good food management, especially in menus and preparation.

In addition to the direct hospital duties of the dietitian there are certain "extracurricular" responsibilities that provide interest and constitute real tests for ingenuity. The average hospital houses more than the patient. There are the nursing, medical, administrative and maintenance personnel. By "housing" is meant those groups that are given permanent residence and maintenance. In other words, it is their home. As in practically every home, there are homelike activities that must be provided, such as parties, teas, receptions and dances. And what is a party without refreshments!

This is where the dietary department comes in for its extracurricular duties, all definitely outside the pale of routine and monotony, in that parties as related to one another must be different in variety and set-up. There are the Christmas party with red and green for color scheme; the Halloween celebration, with yellow and black; a class party with class colors. There are the buffet service with every possibility for variety; the tea table; perhaps a dining room service with probationers for waitresses. For a large and more formal gathering there is the buffet table in the dining room combined with pantry service; for a dance there are refreshing drinks served with a "carry in your hand" sandwich or pastry, which must not soil fingers or drip on the dress.

For Family Parties

Family parties must be different or they are not parties. Sandwiches for the regular lunch planned as a substantial factor for a meal are quite different from the party type. A healthy club sandwich, with chicken, tomatoes and bacon two or three layers high, or a tongue and cheese sand-

wich, generously filled and nice and fresh, has its place on the regular menu. But sandwiches that are dainty and attractive in color and have tasty fillings have to be planned and made ready ahead for parties.

What could be nicer and daintier for a party, for example, than a chicken sandwich? Not the common type of sliced chicken sandwich, however, served with a tomato or a lettuce leaf, but a more delicate variety, prepared especially as party fare. Few of us have not experienced the embarrassment of trying to handle a chicken sandwich in which the bread persisted in sliding off the chicken. And it will do just that, butter or mayonnaise notwithstanding. Furthermore there is a tendency for the bread to dry, and it

The dietitian gets a chance to use her ingenuity through extracurricular activities. Planning parties has a good psychologic effect on so-called routine type of duties.

must be remembered that party sandwiches sometimes stay on the table for an hour or more.

In preparing our party chicken sandwich, therefore, let us take the chicken and grind it with celery, using three parts chicken to one part celery. The celery not only flavors the chicken but provides moisture. For added moisture use mayonnaise. The result is a paste that not only holds the bread together, but keeps it moist.

For those who would experiment, and let it be repeated that the success of these party dishes reflects the ingenuity of the dietitian, the same chicken sandwich may be built into layers in much the same fashion as our mothers made cakes. An efficient method is to trim the crust off a whole loaf and with a cold roast beef knife

cut the bread in thin slices lengthwise of the loaf. Spread these pieces of bread and pile them three, or even four or five layers high. Then after the whole pile is made, cut down in thin sandwiches. You may have as many as five thin pieces of bread.

Added glamour may be supplied by applying a touch of color to the chicken sandwich. It is surprising how important a part color plays in party fare. Using the same method as that described, try keeping the white meat separate from the dark meat, alternating them in the sandwiches. If you like this effect, take the next step, which is to alternate the colors of the bread, i.e. whole wheat and white.

We need not stop with the layer or ribbon sandwich, as it is called. Suppose we spread the same mixture on one piece of bread and then roll as a jelly roll. It can then be sliced to sandwich size. There is no reason, too, why exactly the same color schemes may not be followed.

A Beautiful Buffet Table

So far we have been dealing with a chicken mixture. The same basic principles apply to various cheeses with variety secured by additional ingredients for color as well as taste. Less expensive sandwiches, but equally palatable, are those in which cheese is used as a base with olives, nuts, jellies, parsley, pimiento and even what is sometimes regarded as our plebeian friend, peanut butter. We must not overlook either that old American favorite, the ham sandwich.

Even the briefest discussion of the buffet table would be incomplete without some reference to those dressy, always interesting and enticing canapés. These are to be regarded more as a matter of decorative art than from the standpoint of mere food, just as are regarded the flowers or candlesticks on the table. If the party is to be served from the pantry, they might better be omitted.

In preparing canapés the imagination may well run riot. Of them it may truly be said "anything goes." Chicken livers, sardines, chopped eggs, tomato—there is just no end to it all. Garnishing the tray of canapés helps immensely. A certain concern that puts out a watermelon pickle packs it with a bit of the red showing. It is surprising how much that bit of color adds when used for garnishing.

If it is a winter party you are planning, some hot dish may be required. Again draw upon your imagination. There is the à la king family with chicken, lobster, or shrimp served in patty shells. Or if you must be a bit more economical you can introduce that country cousin egg and mushroom à la king. This is equally palatable, particularly when served on piping hot baking powder biscuits.

In all chicken dishes, whether they happen to be chafing dish or salad,

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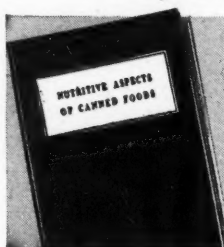
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Buffet table with chafing dish, patty shells, a variety of sandwiches, cakes and cookies, ice cream and coffee and gay with flowers and candles, for the commencement party of the Mount Sinai school of nursing.

the manner in which the chicken is cut is a great factor in attractiveness. Both white meat and dark should be in even cubes of not less than three-quarters of an inch. What about the rest? Well, there are always sandwiches, and every hospital has a tomorrow in which these scrappy pieces can be used effectively.

In the à la king dishes much depends upon the sauce. If chicken is the foundation, the sauce should be made with at least three parts strong chicken broth to one part milk rather than all milk. It is common knowledge, of course, that in any cream sauce the flour should be well cooked. In all à la king dishes using mushrooms, if the flour base is cooked in the same butter as the mushrooms, the flavor of the mushrooms will be found to carry through the cream sauce.

During Lent shrimp may be used. Oyster patties, too, are popular. Here the same principle applies in preparing the cream sauce. The oyster juice is used as a part of the liquid to carry the flavor through. These basic cooking rules are just as applicable to regular meals as to party menus.

In summer the chafing dish may well be replaced with a substantial but appetizing salad of chicken, lobster, shrimp, crabflakes or even fresh, cooling fruit. In preparing the salad mixture, whether chicken or lobster care should be exercised in cutting the individual pieces. The celery also should be carefully cut as to size and should be clean and white. It is well not to be too liberal with it. One part celery to two parts meat is sufficient. It is advisable to marinate with French

dressing and let stand a few hours, adding the mayonnaise, if desired, just before serving. It should be remembered, however, that marinating does not necessarily mean swimming in French dressing.

Most people prefer mayonnaise served separately rather than mixed. What more attractive way of placing it on the plate than in a lettuce leaf cup. Again we realize that garnishing draws upon the dietitian's ingenuity. All sorts of wonders can be achieved with watercress, parsley, pimiento and capers, or in fruit salad with cherries, berries and even nuts. So let us substitute for the proverbial pickle or olive a piece of watermelon pickle nestled in a lettuce leaf, a baby pimiento cup filled with relish or cream cheese served in a bed of watercress.

The buffet table must include beverages. In winter there is coffee, tea or cocoa, according to the kind of party. Then in summer there are many different kinds of punch, always served ice cold. Cherry juice makes an ideal foundation for punches. It blends with all other juices and gives tartness, also color. It is a simple matter to plan ahead and two or three days before the party include on the regular menu some dish made from frosted cherries. These are sour pitted cherries with little sugar and a great amount of juice. The juice is saved for the punch. In fact every party should reach back and forth into the regular menus.

There is always ice cream to be provided, of course; for what would a party be without ice cream? Whether this be bought or made in the institution it should carry out the color

scheme. At one hospital party which was dressed in green, yellow and white, there was no difficulty in having the ice cream company furnish pistachio, apricot sherbert and vanilla, a combination that proved both delicious and pretty. On another occasion when pink and white was the color scheme the ice cream was peppermint and vanilla, which was attractive and particularly tasty.

To accompany the ice cream, pastries should be planned that will carry out the same scheme for daintiness, color and general appeal. An angel food batter made in sheets cut in odd shapes and covered with plain, thin icing with a little curl or two from a fine pastry tube seems much different than the regular angel food baked in the customary loaf tin and cut in wedges for a regular meal service. Baby cream puffs may be filled with whipped cream and topped with colorful icing; baby lady fingers have tips dipped in decorettes; rolled cookies in color or checks may be cut down like jelly roll.

Aside from the food itself the appearance of the buffet table can either make or break the party. Linen, either white or colored, ironed smooth to show the sheen, is an excellent foundation. Flowers carefully selected for color and artistically arranged always contribute; if space permits, silver candlesticks, with the candles carrying out the color scheme, add to the dignity of the setting.

It is well to have accessible all shapes and sizes of paper doilies. Either in white or some harmonizing color they form an effective background for big sandwich platters and individual plates alike.

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A Dietitian in Ole Virginny

By Elizabeth Burruss

THE Southside Community Hospital is an institution of fifty beds located in Farmville, Va. It is almost exactly midway between Lynchburg and Richmond, the only two large cities near by. The city of Farmville is a tobacco town, and while there are one or two manufacturing concerns, the occupation in the surrounding countryside is farming.

The hospital is supported by contributions from the nine counties it serves and by the income from a trust fund. It is a new hospital, and even though small, it is completely equipped in most departments.

Typical Small Hospital

The hospital cares for private patients, ward patients and charity cases. There are eleven single rooms, one double (semiprivate) room and eight four-bed ward rooms. One of the last is the maternity ward, and four other ward rooms are used exclusively for Negro patients. All patients' rooms are on one floor. The rooms are located on one main hall and on wings at each end of the main hall. The front entrance to the hospital is in the exact center of the building; hence the division and reference to East Wing and West Wing.

West Wing is the descriptive term used for all rooms on the right of the front door. East Wing is the term used for all rooms on the left. The four-ward rooms on East Wing are for the use of the Negro patients, and all the other rooms on this wing are occupied by white patients. The majority of the patients are white, but quite a few Negro patients are treated.

The kitchen is located in the basement and on each wing is a small diet kitchen from which patients' trays are served. All trays for Negro patients are served from East Wing kitchen, while West Wing kitchen serves all of the white patients, including those on East Wing. The dining rooms for the nurses and help also are located in the basement, convenient enough for rapid service, but away from food odors and noises incident to food preparation and service.

The basement also contains the laundry and various rooms equipped for use as clinics. These rooms are used by the staff doctors for ambulatory and out-patients. The Negro help (orderlies, maids, cooks, waiters) has rest rooms and locker rooms in the basement.

The kitchen is large, well ventilated and adequately lighted. The floor is of cement and the walls are painted

plaster. The equipment is neither adequate nor the most modern, but it is in excellent condition and conveniently located for its purposes.

The dietary department personnel consists of the dietitian, three Negro men and two Negro girls, one in each diet kitchen on the floor.

The dietitian plans the menus; buys all foodstuffs and foods; checks and inspects deliveries of supplies; supervises the preparation and service of the food for the patients, staff and personnel; plans and prepares the special diet menus and trays; instructs patients when necessary; prepares the liquids for mid-meal nourishments; and visits patients daily. She also checks the dishes and silverware used on the patients' trays, checks the equipment of the kitchens, and inventories and looks after the three dietary storerooms.

Whenever the doctors have a monthly staff meeting, and on the occasion of the semiannual institutes, the dietitian plans, prepares and serves refreshments; or, in the latter case, plans and supervises the preparation and service of the dinner for the institutes.

The work in the kitchen is divided between the cook, the waiter and the dishwasher. The waiter acts as a second cook and relieves for the cook

when he is off duty. The dishwasher serves the meals to the Negro help, prepares vegetables, cleans in the clinic and the basement halls. He also serves the nurses when the regular waiter is off duty or acting as cook.

The Negro maids work almost entirely in the diet kitchens on the floors. They set up, serve and carry the patients' trays, under the supervision of the dietitian. They are responsible for the cleanliness and orderliness of the kitchens and inventory of equipment, dishes and silverware used by the patients. Inventory is made under the supervision and assistance of the dietitian. Maids assist in the main kitchen at times in the preparation of salads and fancy desserts.

Few Labor-Saving Devices

The kitchen workers—the cook and waiter—have one afternoon a week off and alternate Sundays. The dishwasher has one afternoon off a week and every Sunday afternoon. The maids have one afternoon off a week and alternate Sunday afternoons. The hours are long and the pay hardly adequate but the work is divided equally among the three men in the kitchen.

Cooking is done on one large coal range. The only labor-saving electric equipment in the kitchen is a new, stainless steel fruit juice extractor. It has proved its worth by saving time, energy and waste in extracting fruit juices used in the preparation of mid-meal nourishments and liquids.

All dishes are washed by hand. The dishes used on trays are washed in the

For Hot Weather Appetites

IN VIEW of varying individual tastes, it is difficult to serve meals which are always pleasing to every one in an institution. It is more difficult during the summer months when some persons lose their appetites and do not want the heavy meals which must necessarily be served for those who do wish them.

Last summer St. Luke's Hospital, Denver, adopted the plan of having a salad table for the benefit of those who did not wish to eat the regular dinners or suppers served in the dining room. At this table we served a salad bowl (such as is used on many dining cars), bread, butter and jelly, with a choice of desserts and drinks. Eating at this table was optional and members of the personnel ate at it any meals they chose, returning to the regular tables whenever they wished to do so.

This salad table provided an extra choice in menu without involving the

dietary department in the additional labor of preparing a choice of foods on regular dinners and suppers. Sometimes we served vegetable and sometimes fruit salads. The meal costs were not increased, while at the same time the plan gave much satisfaction. The same type of salad was served at the noon and evening meals on a given day, as it was felt that—even though no restriction was placed upon the amount of salad an individual might have—it was not advisable for any one to eat both meals at the salad table. We felt everyone should have one substantial and well balanced meal a day.

While this idea originated with the thought of having lighter meals during the hot weather for those who wished them, we carried it along through the winter for the purpose of varying the menus.

Ruby G. Kysar is the chief dietitian at the hospital.

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floor kitchens by the maids. Those used in the dining rooms are washed in the main kitchen and kept in cabinets there. The dishwashing sink is a large, deep, double sink of galvanized iron and has double drain boards. There are three other sinks in the kitchen, all of galvanized iron. Two of these have double drain boards.

The cooks' table, located in front of the range, also is made of galvanized iron. There is a bain-marie just in front of the range. When the food is ready for service it is placed in it and plates for the dining rooms are served from here.

There is ample working and table space in the kitchen. There are two long, hardwood topped tables and another table of galvanized iron. The latter has cabinet and shelf space beneath it, enclosed behind sliding metal doors. Food containers and jars used to send the foods, beverages and liquids to the floor kitchens are kept here.

Arrangements for Storage

Storage space is adequate except for refrigeration. There is a storeroom for canned goods, paper and soap supplies. Potatoes, onions and vegetables and fruits that do not have to be refrigerated are stored in another room. The room containing the box that makes the ice and the icebox for storing milk, butter, meats and leftovers also contains cupboards and cabinets for the storage of cereals, coffee, bread, flour and sugar. As the temperature in this room is lower than that of the vegetable room the oranges, lemons and more perishable fruits and vegetables are kept here. The dietitian's desk is also in this room and here she keeps files, recipe books, menus, orders and diets. All the storerooms are adequately lighted, ventilated and floored with cement.

The food is sent to the floor kitchens on dumb-waiters. West Wing kitchen has a steam table, but East Wing kitchen does not. Since it is desirable that patients receive food while it is hot and most palatable, the trays for East Wing are served and carried first, under the supervision and with the assistance of the dietitian. Then the trays are served from West Wing kitchen where the food has been placed in the steam table.

Each floor kitchen contains an icebox, double porcelain sinks with double drain boards, and ample table space for holding set-up trays. Each kitchen also contains an electric beverage mixer, an electric toaster and a hot plate. The dishes and silver are stored in cabinets and cupboards in the kitchens. There are also cabinets and cupboards for the storage of paper napkins, tray covers, soap and soap powders, sugar, tea, salt, cereals and condiments.

The hospital has six routine patient diets: liquid; postoperative No. 1

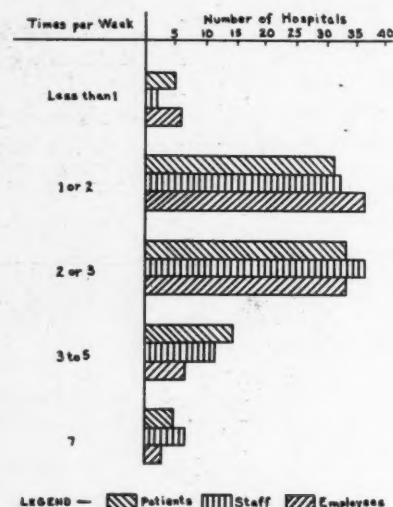
(fruit juices, clear broths, and beverages other than sweet milk); postoperative No. 2 (no meats but the addition of creamed soups, cereals, potatoes and bread); soft; light, and general or regular. There are relatively few calls for special or therapeutic diets, but when they are ordered the dietitian usually prepares and serves them herself.

The dietitian in a small hospital located in a place neither large nor small meets with difficulties in purchasing foods and supplies. This is especially true when she tries to buy meats, fresh fruits and vegetables. Because there are no wholesale produce houses of any kind, many things must be purchased in retail quantities that are preferable to buy in wholesale quantities if possible. This makes food prices higher than desirable, but it has the advantage of enabling the dietitian to demand and get better quality products at times. Then, too, inadequate refrigeration space may prevent keeping large quantities of meat and perishable products.

The dietitian in a small hospital, handicapped by the lack of such equipment as slicers, peelers, puréeers, electric mixers, vegetable steamers and cookers finds the preparation and service of attractive, palatable and dainty foods more difficult and tedious than it would be otherwise. Lack of such equipment increases waste in food preparation, and prevents variety in menus and ways of preparing and serving foods without undue labor and time and trouble.

When Cheese Is Served

In a recent survey on the use of cheese in hospitals, 96 questionnaires were returned and the tabulation of the results shows some rather interesting facts. For example, the two types of cheese most generally used were cream cheese and American cheese. Cottage cheese ranked next with Swiss and others further down



the list. Imported cheeses were used largely for patients and staff, the employees receiving practically none. The accompanying chart shows the frequency with which cheese is used on the regular menu.

While American, cream and cottage cheeses were most generally used, American cheese was listed as having the greatest variety of uses. Some of the dishes prepared with American cheese are macaroni, spaghetti, au gratin dishes of all sorts, soufflés, rabbit and sandwiches. It is also served with pies in a great many institutions. Cream and cottage cheeses are used mainly in salads, pastries and sandwiches.

FOOD FOR THOUGHT

• As if we didn't have enough vitamins to worry about, a Hungarian scientist, Professor A. Szent-Gyorgyi of Szeged University has discovered a new one which he has called vitamin P. This vitamin seems to be closely related to vitamin C. It is found in lemons and paprika (which is probably of particular interest to the Hungarians, who use this seasoning extensively). The exact chemical nature of the vitamin is being studied and it appears to consist of a large molecule containing either 81 or 83 atoms of carbon, hydrogen and oxygen. It is reported to decrease the permeability of the cells to albumin.

• Dr. William C. Rose of the University of Illinois is working on a study that may result in the manufacture of an ideal protein food. He has analyzed the proteins of meat, eggs and cheese, in order to determine which of the amino-acids are essential. Ten must be present in the diet: lysine, tryptophane, histidine, phenylalanine, leucine, isoleucine, methionine, valine, threonine and arginine. Except for arginine, a deficiency of any of the foregoing amino-acids leads to profound nutritional failure with rapid loss of weight. The minimum quantity of each of these essential substances is now being determined. When figures are available, it may be possible for scientists to prepare a mixture that will supply all the protein requirements of the body.

• At Methodist Hospital, Peoria, Ill., a system of cooperation with the graduate nurses is reported by Bernice Lane, dietitian. She states that one-half hour each morning is devoted to receiving the graduate nurses' diet orders of the day. An office employee, in the presence of a dietitian, prepares the slip, which later appears on the patient's tray. This contact with the graduate nurse gives her an opportunity to express herself as to the patient's likes and dislikes, and, on the other hand, gives the dietitian an opportunity to offer helpful suggestions.

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Ward Tray



By Ella Marie Eck, chief dietitian, Albert Merritt Billings Memorial Hospital, Chicago.

Fresh Green Beans and Corn au Gratin



String beans	Cream sauce	Crumbs
Corn	Cheese	Butter

Mix freshly cooked and finely cut string beans with an equal amount of corn cut from the cob. Add enough well seasoned cream sauce to bind and heat. Then fill au gratin dishes. Sprinkle with cheese and bread crumbs, dot with butter and brown under a hot salamander. Serve at once. Do not brown too many too far ahead. A little chopped cooked ham, broiled bacon, corned beef or smoked beef added to this vegetable dish makes an excellent and economical luncheon entrée.—Arnold Shircliffe.

(Continued from page 98)

• Another reason for including plenty of vitamin B in the diet is shown by recent work reported by Dr. Agnes Fay Morgan, Dr. Bessie B. Cook and Dr. Helen G. Davison, all of the University of California. It appears that it may keep hair from turning gray, from observations of graying hair in rats deprived of one part of vitamin B. We all know that vitamin B is composed of many factors, each of which have slightly different effects on the body. A vitamin B preparation made from rice bran filtrate affects the gray hair in rats. Rats deprived of this "filtrate factor" turned gray, but adequate amounts of it prevented or cured the condition. It is interesting to learn that this filtrate factor is found in cornstarch, in view of the fact that corn has been supposed to be one of the causes of pellagra, possibly because it is found in the diets of most pellagra patients. The filtrate factor, however, is not only found in cornstarch, but has been thought to be the pellagra-preventing part of the vitamin and the same preparation that has actually cured pellagra.

• A new breakfast food, which is a good source of vitamin B, has just made its appearance. Dr. Henry Borsook of Pasadena, Calif., reported at the American Institute of Nutrition that it is what millers call "the scalp of the sizings." Formerly discarded, it has been found to be one of the most palatable of the cooked cereals, with the additional advantage of being very cheap. With the use of this cereal, rapid recoveries have been brought about in patients suffering from vitamin B deficiency. The food is not on the market as yet, but many good vitamin B foods are available. In the breakfast food line there are whole wheat bran and the whole grain cereals, particularly wheat and oats; and so far as other foods are concerned lean meats, especially pork, fresh compressed yeast cakes, milk, and dried and green beans are excellent sources of this vitamin.

• A new treatment for stomach ulcers was reported by Dr. Asher Winkelstein, of New York, to the Medical Society of the State of New York at its Rochester meeting. For some time frequent feedings of small amounts of milk and cream have been part of the standard medical treatment for this condition. These feedings, alternated with doses of alkaline powders, such as bicarbonate of soda, are given to neutralize the acid normally secreted by the stomach, which irritates the ulcer and prevents its healing. Dr. Winkelstein has developed a constant feeding of milk, a drop at a time through a tube, basing his theory on studies of stomach secretion especially at night. He emphasized the importance of nervous oversecretion of acid by the stomach in such cases.



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October Dinner Menus for the Small Hospital

By Ruth M. Hornsby

Dietitian, Memorial Hospital, Owosso, Mich.

Day	Soup or Appetizer	Meat or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Bouillon With Parsley	40-Fathom, With Tartare Sauce	Mashed Potatoes	Hot Pickled Beets	Confetti Coleslaw	Peach Shortcake
2.	Noodle Soup	Swiss Steak	Diced Buttered Potatoes	Stewed Tomatoes	Mock Salmon Salad	Caramel Custard
3.	Chicken Rice Soup	Chicken Fricassee With Biscuits	Stuffed Sweet Potatoes	Creole String Beans	Beet and Egg Salad	Orange Ice
4.	Bouillon	Roast Lamb With Grape Jelly	Macaroni Puff	Fresh Lima Beans	Peach and Browned Coconut Salad	Cottage Pudding, Lemon Sauce
5.	Potato Soup	Arabian Pork Chops	Stuffed Baked Potatoes	Escalloped Eggplant	Cherry and Grape Salad	Coconut Layer Cake
6.	Julienne Broth	Ham Loaf	Mashed Potatoes	Baked Squash	Stuffed Prune Salad	Apricot Sherbet
7.	Tomato Soup	Breaded Liver	Paprika Potatoes	Creamed Cabbage	Jellied Vegetable Salad	Pineapple Rice Dainty
8.	Clam Chowder	Baked White Fish	Potato Cakes	Harvard Beets	Coleslaw	Fruit Gelatin
9.	Baked Bean Soup	Beefsteak Roll, Mushroom Sauce	English Browned Potatoes	Creamed Onions	Mixed Fruit Salad	Black Walnut Cup Cakes
10.	Grapefruit Supreme	Breaded Veal Steak	Diced Buttered Potatoes	Buttered Peas and Carrots	Stuffed Celery	Boston Cream Pie
11.	Spiced Tomato Broth	Baked Beef Heart With Horseradish	Mashed Potatoes	Wax Beans	Pear and Cheese Salad	Steamed Cherry Pudding, Cherry Sauce
12.	Potato Mongole	Sausage Patties, Fried Apples	Steamed Potatoes	Swiss Chard	Mixed Pickles	Pumpkin Sponge Custard
13.	Mulligatawny Soup	Smothered Steak	Diced Buttered Potatoes	French Fried Onions	Stuffed and Ripe Olives	Peach Melba
14.	Cream of Spinach Soup	Fricassee of Veal	Boiled Potatoes	Diced Carrots With Parsley	Head Lettuce, Thousand Island Dressing	Steamed Fig Pudding
15.	Iced Tomato Juice With Lemon	Broiled Trout With Lemon Butter	Parsley Potatoes	Cauliflower à la Parmesan	3% Vegetable Salad	Prune and Apricot Gingerbread
16.	Golden Bouillon	Roast Beef and Brown Gravy	Browned Potatoes	Mashed Summer Squash	Jellied Tomato Salad	Butterscotch Tapioca
17.	Giblet Soup	Chicken Gumbo With Rice	Buttered Celery	Javanese Corn	Cinnamon Apple Salad	Raspberry Sherbet
18.	Cream of Mushroom Soup	Pan-Broiled Lamb Chops	Creamed Potatoes	Browned Carrots	Apricot and Nut Salad	Rice Custard
19.	Canadian Cheese Soup	Boiled Fresh Tongue	Mashed Potatoes	Spinach à la Béchamel	Jellied Pineapple and Cucumber Salad	Coffee Sponge Cake
20.	Consommé With Egg Drops	Stuffed Veal Breast	Buttered Peas	Creamed Salsify	Head Lettuce, Russian Dressing	Peach Ice Cream
21.	Alphabet Soup	Porky Pie	Browned Carrots	Stewed Tomatoes	Corn Relish	Pineapple Up-Side-Down Cake
22.	Cranberry Juice Cocktail	Salmon Loaf, Cucumber Sauce	Baked Potatoes	Green Beans	Apple and Date Salad	Lemon Chiffon Pudding
23.	Beef Broth	Broiled Steak	Oven-Fried Potatoes	Piquante Cabbage	Chef's Salad	Chocolate Peppermint Roll
24.	Okra Broth	Baked Fresh Ham	Mashed Potatoes	Baked Hubbard Squash	Mixed Fruit Salad With Whipped Cream	Maple Nut Ice Cream
25.	Scotch Broth	Hamburg Patties and Cream Gravy	Steamed Potatoes	Browned Parsnips	Sliced Orange and Date Salad	Banana Tapioca
26.	Cream of Pea Soup	Veal Birds	Parsley Potatoes	Creamed Salsify	Head Lettuce, Roquefort Dressing	Cherry Pudding
27.	Vegetable Soup	Boiled Beef With Noodles		Buttered Peas	Pear Macaroon Salad	Honey All-Bran Pudding
28.	Oxtail Soup	Roast Pork Loin	Mashed Potatoes	Glazed Onions and Carrots	Peach Pickles	Apple Crumb Pudding
29.	Noodle Soup	Pan-Boiled Herring, Egg Sauce	Potato Loaf	Spinach With Egg	Celery Cabbage, French Dressing	Snow Pudding, Cherry Sauce
30.	Tomato Soup With Rice	Lamb and Pimiento Loaf	Au Gratin Potatoes	Stewed Celery	Olives and Sweet Relish	Chocolate Cake
31.	Grape-Cider Punch	Baked Chicken	Mashed Potatoes	Hubbard Squash, English Style	Endive, French Dressing	Black Walnut Ice Cream

Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago.

"This Allergy Diet Sheet has been a life saver for me!"



A busy man can't take the time to look up every food he eats. I know I made a lot of troublesome mistakes before my doctor gave me this diet sheet for my special allergy. Now I'm sure just what I can or can't have—because it's all down here in black and white."

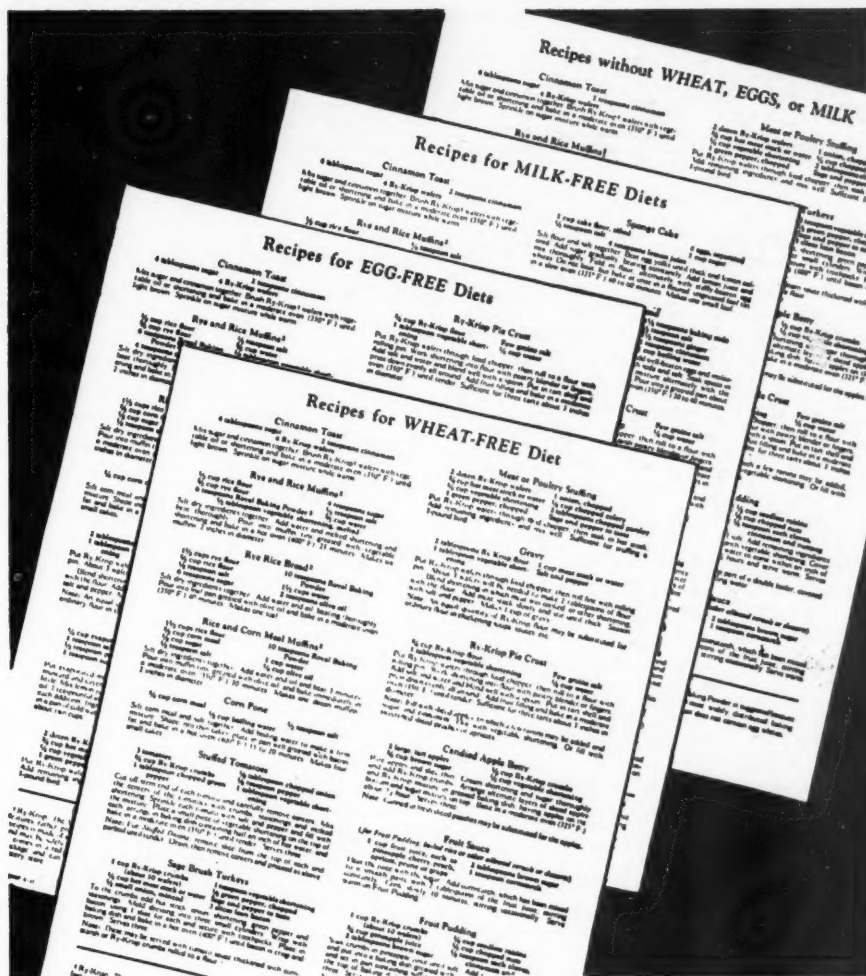
That's true, doctor! These sheets, prepared to help both you and your patient, do tell exactly what may be eaten by the patient who is sensitive to wheat, milk, eggs or a combination of all three.

The allergy diet sheets were prepared in cooperation with recognized authorities. Today they are being used by physicians and allergy clinics all over the country.

Each sheet clearly states just what foods are allowed

and what forbidden, according to the patient's particular sensitivity. On the reverse side are safe and tempting recipes. Each sheet also provides space for your patient's name, the date, your own personal instructions and signature. No advertising appears on them. None are sent to the laity. They are for professional distribution only.

We'll gladly send you copies of these sheets and samples of Ry-Krisp. Taste these crisp, whole rye wafers and you'll know why they play such an important part in wheat, milk or egg-free diets. And, of course, they're perfectly safe—because they're simply flaked whole rye, salt and water. Just use the coupon to send for them, today!



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NEWS IN REVIEW

Dr. Clarence Cook Little to Be Convocation Speaker at Annual Meeting of A. C. H. A.

The director of the American Society for the Control of Cancer, Dr. Clarence Cook Little, will be the convocation speaker at the fourth annual meeting of the American College of Hospital Administrators in Atlantic City, September 12 to 13. His address will be given Sunday evening following the induction of newly elected fellows and members.

Announcement that the distinguished educator and authority on cancer will appear on the convention program follows closely upon the heels of the disappointing news that Capt. J. E. Stone, secretary of the Birmingham Hospitals Centre, Birmingham, England, who originally was scheduled for this address, would not be able to come to the United States at that time.

Doctor Little, in addition to his aggressive national campaign mobilizing and directing the "Women's Field Army" for combating cancer, carries on research work at the Roscoe B.

Jackson Memorial Laboratory, Bar Harbor, Me., of which he is director. He has also served as president of the universities of Maine and Michigan. He is recognized for liberalism in education and his numerous works dealing with education, genetics, cancer research and social problems.

An open session for hospital administrators will be held in Lewis A. Sexton Hall of the convention auditorium at 9:30 a.m. Monday, September 13, at which Howard E. Bishop, president of the A. C. H. A. and administrator of the Robert Packer Hospital, Sayre, Pa., will preside. Father Alphonse M. Schwitalla, S.J., president, Catholic Hospital Association, and dean of the St. Louis University School of Medicine, will present the final report of the committee on training hospital administrators. Dr. Malcolm T. MacEachern will talk on institutes for hospital administrators.

This year will mark introduction of the new type of junior memberships.

Preview of Convention Is Packed With Drama

(Continued from page 52)

stage in favor of Commissioner William J. Ellis of the New Jersey department of institutions and agencies.

A trial is going on as we enter Alfred C. Meyer Hall, with S. Frank Roach of Jersey City as presiding justice. Edgar C. Hayhow of Paterson is state's attorney. Disturbing Conditions vs. Corrective Procedure is on the day's docket, and the professional jurors represent power plant, paint and painting, plumbing equipment, laundry, floor maintenance, operating and maintenance costs of the mechanical division.

From the preview have been deleted the names of the winners of the National Hospital Day awards on Monday evening and even the name of the banquet speaker on Wednesday. We do hear Joseph Bentonelli of the Metropolitan Opera and the Westminster Choir of Princeton in some stirring songs.

In fact, this preview is just a bare announcement of the real Atlantic City thriller, which begins on September 13 with a stupendous, all-star cast, and an audience of some 3,500.

Hospital Institute Furnishes Grounds for Advancement

Two weeks of note-taking—mental and manual—will bring to the 100 or so registrants at the fifth annual Institute for Hospital Administrators to be held in Chicago, August 30 to September 10, good grounds for advancement.

Mornings will be given over to lectures and seminars, afternoons to successive demonstrations in fourteen Chicago hospitals and four evenings each week to round tables, with Dr. Malcolm T. MacEachern and his associates conducting the study on topics related to administration.

Supt. Fred G. Carter of Christ Hospital, Cincinnati, will do the lecturing on general organization, and Dr. Clyde D. Frost, director of Union Memorial Hospital, Baltimore, on business management.

Professional and community relationships are the forte of Dr. G. Harvey Agnew. Dr. Fred L. Adair will discuss maternity care in the general hospital. Dr. James Moss Beeler, head of the general hospital at Spartanburg, S. C., will talk on the hospital as a health center.

The big subject of nursing will be treated by Edna Newman, director of

the nursing school of St. Luke's, Cleveland, and by Dr. Claude W. Munger of St. Luke's, New York City.

J. Lincoln MacFarland, superintendent of laundry and housekeeping, Woman's Hospital, Philadelphia, will direct attention to maintenance of plant and housekeeping.

The A. M. A. will send Dr. William D. Cutter and Homer Sanger to give their ideas on interns and intern training. Dr. William H. Spencer of the school of business, University of Chicago, will talk on the hospital's legal relationships.

C. Rufus Rorem, director of the committee on hospital service of the American Hospital Association, will talk on group hospitalization. All day Tuesday, September 7, will be spent at Evanston Hospital.

Three Chicago Nurses Are Assaulted, One Murdered

The third attack upon nurses in Chicago hospitals, one of which ended in murder, may bring about concerted action by the Chicago Hospital Council, Dr. Arnold F. Emch, executive director of the council, has declared.

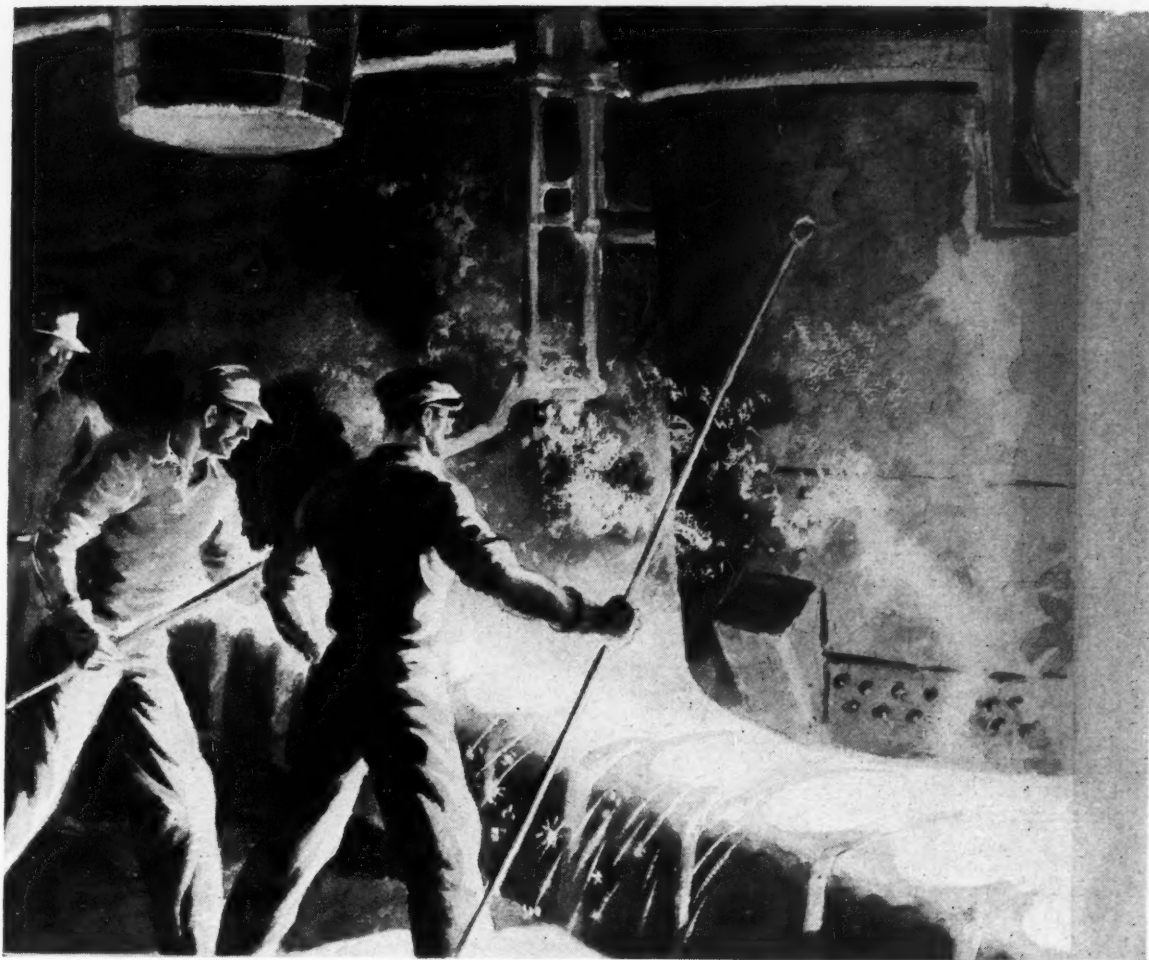
The murdered victim was a nineteen-year-old student nurse at the Chicago Hospital. Another victim of an attack was the superintendent of nurses at the Jefferson Park Hospital, who was severely hacked by a blade on the arms and chest. The third took place at St. Luke's Hospital several months ago. All were attacked in nurses' quarters adjoining the hospitals. Chicago police have ordered a close watch kept at all hours on all hospitals, nurses' homes, hotels and apartment buildings where sleeping rooms are accessible by means of fire escapes.

New Hospital in New Hampshire

Erection of a \$333,000 structure for Sacred Heart Hospital, Manchester, N. H., is now under way. Of fireproof construction throughout, the only wood in the building will be window frames and doors. The building will be of light gray brick, limestone and steel construction. The hospital was founded nearly fifty years ago, and will be a 100-bed hospital when the new structure is completed.

Record Librarians to Chicago

The ninth session of the Association of Record Librarians of North America will be held at the Congress Hotel, Chicago, Oct. 25 to 29. Mrs. Frieda N. Tranter, medical records librarian, Children's Memorial Hospital, Chicago, is chairman of the committee on arrangements, and Jennie Jones, medical records librarian of Maryland General Hospital, Baltimore, and president-elect of the association, is chairman of the program committee.



IN THE TREATMENT OF *BURNS*

AMERTAN' (Tannic Acid Jelly, Lilly) combines the therapeutic efficacy of a 5 percent tannic acid solution with the antiseptic value of 'Merthiolate' (Sodium Ethyl Mercuri Thio-salicylate, Lilly), in a water-soluble jelly base. It is ready for immediate use; is easily applied; does not complicate the

removal of dressings; can be washed off with ordinary water. The 'Merthiolate' content inhibits bacterial growth, thereby lessening danger of infection. 'Amertan' greatly simplifies the treatment of burns. It is supplied through the drug trade in one and five-ounce tubes, one and five-pound jars.

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Protestant Hospital Meeting Will Precede Large General Conclave at Atlantic City

The common interests of church hospitals will draw administrators together in Atlantic City for the meeting of the American Protestant Hospital Association, September 10 to 12, just before the opening of the large general hospital conclave of the American Hospital Association.

The program has been divided into three general sections, concluding with a religious service on Sunday morning, September 12. Administrative methods as applied to a church hospital will be the theme of the opening day's program, September 10, and will include talks on the following topics: office, Frank Walter, superintendent, St. Luke's Hospital, Denver; housekeeping, Mrs. Doris L. Dungan, housekeeper, West Jersey Homeopathic Hospital, Camden, N. J.; dietary department, Esther Wolfe, superintendent, St. Andrew's Hospital, Minneapolis; operating room, Stewart B. Crawford, assistant superintendent, Maryland General Hospital, Baltimore; plant and equipment, R. A. Nettleton, superintendent, Methodist Hospital, Des Moines; purchasing department, May Middleton, superintendent, Methodist Hospital, Philadelphia.

A round table will follow under direction of E. I. Erickson, superintendent, Augustana Lutheran Hospital, Chicago, and a skit, "The Admitting Office," will be directed by Dr. A. F. Branton, superintendent, Willmar Hospital and Clinic, Willmar, Minn.

"The Type and Extent of Religious Work in a Church Hospital" will be the subject discussed by the Rev. Paul Wendt, superintendent, Evangelical Deaconess Hospital of Milwaukee, at the evening session, followed by a discussion to be led by Rev. C. O. Peterson, superintendent, Norwegian Lutheran Hospital, Brooklyn.

Plan Nursing Session

The session on nursing schools on September 11 will include talks by Meta Pennock, editor, *Trained Nurse and Hospital Review*, New York City; Martha Roberson, superintendent, Medical and Surgical Memorial Hospital, San Antonio, Tex.; Lillian Williams, superintendent, Laconia Hospital, Laconia, N. H.; Margaret Ashmun, president, New Jersey State Nurses' Association, Orange Memorial Hospital, Orange, N. J., and Robert E. Neff, superintendent, University of Iowa Hospitals, Iowa City.

Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, will speak on "The Place of the Board of Trustees in a Hospital Picture" at the trustees' section on September 11.

Other speakers who are included on the program will be the Hon. Herman L. Ekern, Chicago attorney, who

will speak on "Social Security as Applied to Tax-Exempt Institutions"; the Rev. N. E. Davis, D.D., Methodist Episcopal Homes and Hospitals, Columbus, Ohio, on "A Survey of Church Hospitals"; Bryce L. Twitty, superintendent, Baylor University Hospital, Dallas, Tex., on "Group Hospitalization as It Concerns the Church Hospitals," followed by discussions by E. A. Van Steenwyk, executive secretary, Minnesota Hospital Service Association, and Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland.

Dr. Basil C. MacLean, president of the American College of Hospital Administrators and superintendent of the Strong Memorial Hospital, Rochester, N. Y., and the Rev. Joseph B. C. Mackie, D.D., pastor, Northminster Presbyterian Church, and trustee, Presbyterian Hospital, Philadelphia, will appear as headliners on the banquet program.

Three sermonettes by hospital executives will proceed the regular sermon on Sunday by Rev. C. C. Jarrell, D.D., of Atlanta, Ga. They will be given by A. G. Hahn, business administrator, Protestant Deaconess Hospital, Evansville, Ind.; E. E. King, superintendent, Missouri Baptist Hospital, St. Louis, and Robert Jolly, administrator, Memorial Hospital, Houston, Tex.

Laboratory Technicians Ask \$1,500 Minimum Wage

Increased pay for New York City laboratory technicians has been urged upon Health Commissioner John L. Rice and Hospital Commissioner S. S. Goldwater by the city affairs committee, which criticized present salary scales as "wholly inadequate."

Though entrusted with high responsibilities in preparing toxins, antitoxins and vaccines, while facing great hazards from contact with dangerous germs, these trained experts now receive less on an average than street cleaners, according to John Haynes Holmes, chairman, and Frederick L. Guggenheimer, executive director of the committee. They recommend a minimum of \$1,500 for the lowest grade employee in the department.

Celebrates 75th Anniversary

The seventy-fifth anniversary of the founding of the Royal Columbian Hospital, New Westminster, B. C., was celebrated recently. Honored guests included Hugh Murray, one of the few survivors of the original party of Royal Engineers that left England in 1859 to establish Sapperton, afterward New Westminster. The hospital has grown from a wooden structure built in 1861 to the present plant.

Administration Residency Open to Suitable Man

A vacant residency in hospital administration has just been announced by the Hospital for Joint Diseases, New York City. The appointment is to begin January 1 and to extend for a period of three years.

Only candidates who have the following requirements are eligible to apply: (1) graduation from a grade A medical school; (2) two years' general internship in a hospital with a bed capacity of at least 200; (3) reliable testimony and observation as to personal qualities, and (4) a desire to make hospital administration a life work rather than a means of finding temporary employment.

The hospital provides full maintenance and a stipend of \$600 for the first year, \$900 for the second year, and \$1,200 for the third year. Applications should be addressed to Dr. J. J. Golub, director.

Paris Hospital Asks Aid

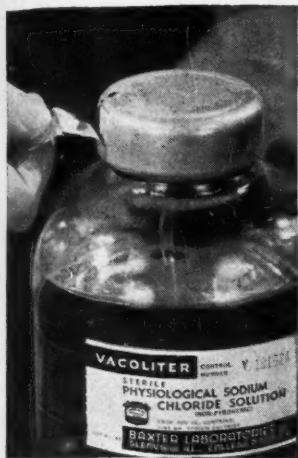
Every American visitor to France as well as American residents in France is being asked to contribute toward support of the American Hospital of Paris, which has made an appeal for financial aid through the Paris edition of the New York *Herald-Tribune*. In 1936 the hospital rendered services to Americans who were unable to pay in the amount of \$68,897. The constantly increasing deficit of the hospital is too much for the American colony of Paris alone. The hospital would be able to keep open by refusing free cases, but instead it is asking for an annual subscription of \$20 from Americans in Europe.

University Has Free Hospital Care

Despite drastic reductions in student entrance fees, beginning with the fall semester, the University of Missouri will continue to provide free medical attention, hospital care and other health services, the board of curators has announced. The free medical attention and hospitalization of students are a distinctive service rendered by the University of Missouri, one of the few state universities offering complete hospital privileges to students without additional charge. Students not residing in Missouri will not share in the fee reduction provided.

Appeals for More Nurses

An appeal for more nurses has been issued by the Brooklyn Nursing Bureau. The eight-hour working day for nurses has resulted in a shortage of trained help, especially in Brooklyn and Long Island hospitals. Hospitals still maintaining a nine-hour working schedule cannot change to the shorter period schedule unless they obtain more nurses, it is said.



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NEW BUILDING PROJECTS

HACKENSACK, N. J.—The new six-story wing of the Hackensack Hospital was opened recently for public inspection. The addition, costing approximately \$270,000, was made possible through gifts and a bequest of \$100,000 by the late Senator William Johnson. The building will replace the old south wing which will be razed.

GLENS FALLS, N. Y.—Final plans for a new structure to be added to the Glens Falls Hospital have been completed and a drive for funds opened in early summer. The addition will be part of the present hospital, which will be completely remodeled within to coordinate with the new structure. This new section will be one and a half times longer than the present building, and will have a maximum capacity of 190 beds, twice the present maximum capacity. In event of an epidemic or catastrophe in the community, five solariums and an assembly room can be utilized by installation of beds. Rose Q. Strait, superintendent, has pointed out. Better emergency facilities will be provided by a complete accident department on the ground floor. Quiet rooms will be installed, and a complete bacteriologic laboratory and x-ray department will make the hospital well equipped for diagnostic purposes.

NEW YORK CITY—John Russell Pope, architect, is preparing plans for the \$3,000,000 Triborough Hospital for tuberculous patients to be erected adjacent to the new Queens General Hospital, in Jamaica, Dr. S. S. Goldwater, commissioner of hospitals, has announced.

CINCINNATI—An anonymous gift of \$20,000 to the University of Cincinnati Medical College will be used to remodel one of the General Hospital wards as an isolation unit, the board of directors has revealed.

YOUNGSTOWN, OHIO.—Construction of a new wing for the South Side unit of the Youngstown Hospital, to cost approximately \$250,000, will begin Sept. 1. Architects Kling and Canfield have drawn plans for the building, to be five stories high, of brick and stone, built east of the present structure. Two floors will be given over to two and four-bed rooms. The top floor will house the children's department. The emergency ward, X-ray rooms, crippled children's room and offices will take up the remainder of the building.

HARRISBURG, PA.—A construction program costing \$1,300,000 is being planned at the Harrisburg State Hospital to relieve crowded conditions in the hospital. A cottage for the isolation of tuberculous patients will be

erected on the grounds separate from other institutional buildings.

ELKIN, N. C.—An addition is being built to Hugh Chatham Memorial Hospital. The annex will be of the same type of architecture as the original building and will contain a reception room, staff offices, physicians' offices, and interns' quarters. The second floor will include semiprivate rooms and the third floor will be used as a children's ward, a solarium and semiprivate rooms. The annex will double the capacity of the hospital. It is being financed through donations from the Duke Foundation and private subscriptions.

RALEIGH, N. C.—A new building for Rex Hospital was opened recently for public inspection. The unit has a capacity of 200 beds and was built from funds from a PWA grant of \$100,000 and a bond issue of \$287,000.

MEMPHIS, TENN.—Construction was expected to begin during August on three new additions to the Baptist Hospital, including a new wing, an annex connecting the physicians' and surgeons' building with the main hospital, and a second floor to the present garage. With a capacity of 100 beds, the new wing will increase the total to 500, making it possible to handle 20,000 patients annually, and a total of 175 charity beds. "This will give Memphis the largest Baptist hospital in the world and will represent total investments of more than \$3,000,000," according to A. E. Jennings, chairman of the hospital board.

HOUSTON, TEXAS—The \$750,000 addition to St. Joseph's Infirmary is nearing completion and is expected to be ready for occupancy this fall. The annex is in the form of two units, the obstetric with seventy-five beds, and the pediatric unit, sixty beds. Both will be air conditioned. The present general infirmary has 250 beds. Forty-five Sisters of the Incarnate Word are attached to the infirmary now and twelve will be added when the new units are completed.

LONGVIEW, TEX.—The facilities of the new Markham-McRee Hospital with a fifty-bed capacity and complete equipment are available to a large group of physicians in and near Longview. There are three floors, the walls and ceilings are insulated for sound and temperature control and the building is of semifireproof construction. Pastel walls and Venetian blinds are used throughout the building and special attention has been given to the furnishing of the private rooms. There is a section for Negro patients.

Quincy Hospital Contends That It Has Civil Service

Appointment of an ambulance driver through civil service again has brought the question as to whether employees of the Quincy City Hospital, Quincy, Mass., are under civil service.

While the municipal courts of Quincy formerly held that hospital employees were not under civil service, the institution has been operating under civil service regulations for a number of years. The board of trustees has taken this attitude on the advice of two members, both attorneys, according to Joseph B. Groce, chairman. Recently it made an attempt to secure civil service by getting a bill introduced into the general court, which was vetoed by the governor of Massachusetts on the grounds that such a measure should go on the ballot and not be determined by legislative action.

The board will continue to operate the hospital under civil service regulations and further its efforts to obtain civil service ratings for employees or get high court assurance that they now exist.

The Sun Never Sets at Edgewater Solarium

A solarium that is both spa and hospital has been constructed by the Edgewater Hospital of Chicago. The solarium will be used for the treatment of muscular, nervous and metabolic disorders, and includes facilities for special mineral and health baths, sun treatments, massage and exercises. Arthritis can be treated in the physiotherapy department of the solarium.

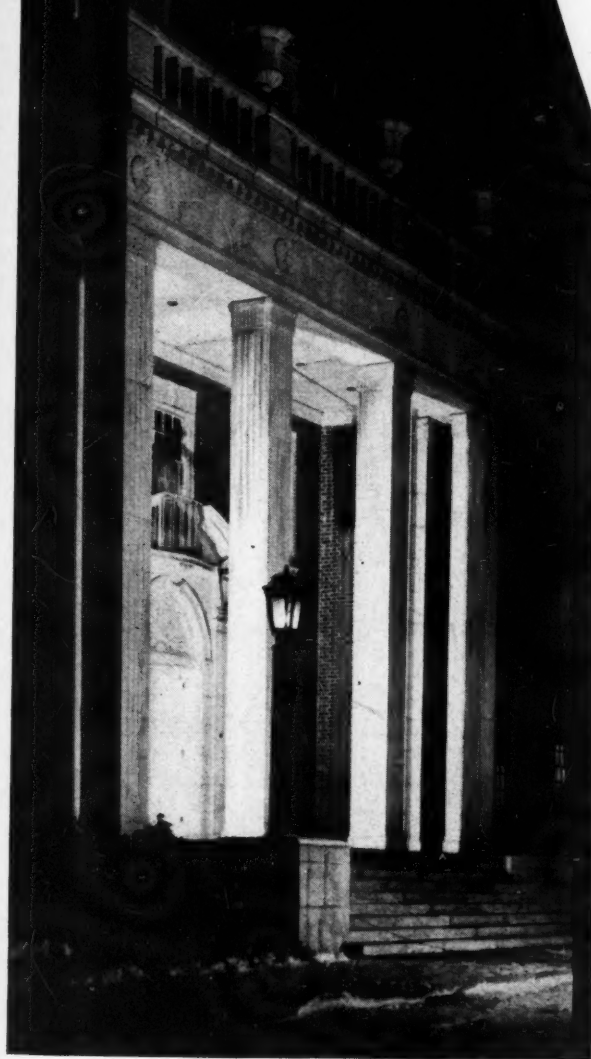
The solarium, which measures 50 by 40 feet, is entirely enclosed by a glass that permits the penetration of ultraviolet rays. When the weather is sunny, the top and sides of the room can be opened to permit direct entrance of solar rays. But if the sun is not shining, the patient has only to pull a switch and special sun and ultraviolet ray lamps turn on.

Governor Opens Hospital to Aid Paralysis Victim

In an attempt to save the life of an infantile paralysis victim, Gov. Clyde Tingley ordered the doors of the \$1,000,000 Carrie Tingley Hospital for Crippled Children at Hot Springs, N. M., opened twenty-five days before schedule.

Dr. John D. Martin, young El Paso, Tex., intern, delivered the patient to the hospital after a grueling five-hour ambulance ride over the 121 miles from El Paso to Hot Springs. The patient rallied in the 1,000-pound iron respirator, but later died.

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The public helps the hospital that shows leadership. The public supports soundly conceived and expertly presented hospital programs. The people of a community are proud to ally themselves with a hospital management and board which show foresight and courage.

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Association of Nurse Anesthetists Announces Atlantic City Program Concurrent With A. H. A.

One of the allied hospital groups holding its national meeting in Atlantic City in conjunction with the American Hospital Association convention is the National Association of Nurse Anesthetists, which will hold a five-day session, September 13 to 17.

The first speaking program will be the afternoon session on September 14 with Louise Schwarting of the Lutheran Hospital, Fort Dodge, Iowa, presiding. This program will be devoted to various phases of anesthesia service and will include the following list of speakers:

Charles G. Margiotti, attorney-general of Pennsylvania; Laura Bryant, Cooper Hospital, Camden, N. J.; Faye Fulton, Methodist Hospital, Philadelphia; Dr. Howard A. Bradshaw, Jefferson Hospital, Philadelphia; Sister Rudolph, St. John's Hospital, Springfield, Ill.; Dr. Donald Guthrie, Dr. Felix A. Hughes and Dr. Charles H. DeWan, pathologist, Robert Packer Hospital, Sayre, Pa.; Mrs. Jennie Hauser, Memphis General Hospital, Memphis, Tenn., and Dr. Moses Behrend, Philadelphia.

At the banquet that evening, Robert Jolly of the Memorial Hospital, Houston, Tex., will be the guest speaker.

At the morning session on September 15, Dr. Malcolm MacEachern, associate director of the American College of Surgeons, will discuss "Anesthesia Records," and Dr. Joseph C. Doane, editor of *The MODERN HOSPI-*

TAL and superintendent of the Jewish Hospital of Philadelphia, will speak on "What the Hospital Anesthetist Is and Is Not." Anna Willenborg of the St. Joseph Hospital, Chicago, will preside over this session.

The relation of anesthesia to various kinds of surgery will comprise the afternoon session, over which Mae Stone, Presbyterian Hospital, Newark, N. J., will preside. Among the speakers will be Dorothy Hoadley, Methodist Hospital, Fort Worth, Tex.; Dr. Clifford B. Lull, chief of gynecology and obstetrics, Pennsylvania Hospital, Philadelphia; Dr. William T. Lemmon, Philadelphia General Hospital; Dr. Charles Lintgen, Philadelphia; Dr. George Muller, professor of surgery, Jefferson Medical College, Philadelphia, and Melvin Sutley, superintendent, Delaware County Hospital, Philadelphia.

Ida Maude Edwards of Strong Memorial Hospital, Rochester, N. Y., will preside over the afternoon program on September 16, on which Sister Borromea Suplicka, St. Francis Hospital, Peoria, Ill., Mrs. Frances Hess, Long Island College Hospital, Brooklyn, N. Y.; Esther Myers, Queens Hospital, Honolulu, T. H., and Verna M. Rice of Mobile, Ala., will appear.

Dr. David B. Allman, chief surgeon, Atlantic City Hospital, will conduct a clinic at that hospital on the morning of September 17, at the final session.

Grant Hospital Will Open Medical Librarians' School

Chicago's Grant Hospital will open a school for medical record librarians on September 15 under the direction of Mrs. Edna K. Huffman, R.R.L., past president of the Association of Record Librarians of North America and former medical record librarian at St. Joseph's Hospital, Chicago.

The new school has received conditional approval from the Association of Record Librarians of North America, and is to receive full approval on opening.

The quota of students for September and November entrance dates already has been filled. Other entrance dates have been set tentatively for January and April, Mrs. Huffman said, as the school will operate on a rotating service of individual instruction. The length of time for completion of the course is set at nine months, and entrance requirements include at least one year of college or graduation from an accredited school of nursing and proficiency in shorthand and typewriting.

Donates \$350,000 to Hospital

A sum of \$350,000 for erection of a children's annex to St. Francis Hospital of Hartford, Conn., has been made by Catherine H. Dillon in memory of her brothers, the late Edward H. Dillon, financier and merchant of Bridgeport, and Charles Dillon, Hartford banker. Edward H. Dillon had served on the board of directors of the hospital during his lifetime and had made many gifts to the hospital. The hospital will be the first of its kind in the state devoted exclusively to child patients. It will be three stories high, of Georgian colonial design, and will connect with the main hospital.

Establish Cancer Institute

Following closely on the gift of \$10,000,000 by a private donor to Yale University for cancer research is the bill establishing a National Cancer Institute as a division of the U. S. Public Health Service which has passed both houses of Congress. The bill will become a law thirty days after its signature by the President, but in accordance with congressional practice it carries no appropriation.

Prefers Budgetary Action

Enactment of the Burke Bill, which would provide \$1,000 a year salaries plus maintenance for interns in New York City hospitals, would add \$500,000 a year to the hospitals departmental budget, Dr. S. S. Goldwater, commissioner, said. Doctor Goldwater said it was his best judgment that salaries for interns should be dealt with along the usual budgetary lines.

Strike at Charity Hospital Prohibited by Injunction

Holding that charitable institutions are exempt from provisions of the Little Wagner Act, Justice Albert Conway of the Brooklyn Supreme Court has given the Jewish Hospital of Brooklyn a sweeping injunction against Local 171 of the Hospital Employees Association.

The union is prohibited from calling, instigating or continuing a strike, picketing within three blocks of the hospital, causing sympathizers or other allied or affiliated unions to do so, holding meetings or causing crowds to collect near the hospital.

The Little Wagner Act controls a section of the Civil Practice Act, which labor organizations invoke when employees seek injunctions, and repeals any parts inconsistent, Justice Conway pointed out in his decision. If the decision is upheld, it will be the death knell of unions in hospitals that depend partly on charitable contributions to carry on their work.

Meanwhile in New York City a complaint was lodged with Mayor La-

Guardia and Commissioner S. S. Goldwater that three municipal hospitals had hampered employees in attempts to unionize. The union named Cumberland, Kings County and Bellevue Hospitals, and asked that the superintendents be acquainted with employees' rights to organize.

Closes Randall's Island Hospital

With the closing of the old Randall's Island Children's Hospital, the New York City department of hospitals has discontinued as a municipal function the treatment of mentally defective children. Although the state department of mental hygiene has the duty of caring for mental defectives, because of limited facilities transfers to state institutions have been made gradually. Mental hygiene clinics at Bellevue and Kings County Hospitals, conducted by the New York City department of hospitals, will function as application bureaus for the state institutions. The site of the old hospital will become a recreational center.

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NAMES IN THE NEWS...

DR. ALLAN CRAIG, director of Charlotte Hungerford Hospital, Torrington, Conn., has been appointed medical director of the Eastern Maine General Hospital, Bangor. A medical center is proposed and a building program will be undertaken shortly. Doctor Craig will take over his new duties October 15.

J. D. COLMAN, executive secretary of the Hospital Council of Essex County and the Hospital Service Plan of New Jersey, has resigned his position to accept the post as director of the Associated Hospital Service of Baltimore. Mr. Colman assumed his new duties September 1.

LOUISE SANFORD is the new acting superintendent of the Addison Gilbert Hospital, Gloucester, Mass., succeeding **MARTHA JANE AVARD** who resigned August 1.

DR. LORIN KERR, JR., aged twenty-eight, has been appointed to fill the recently combined positions as head of the bureau of medical relief and superintendent of the Municipal Hospital for Contagious Diseases in Toledo, Ohio. Doctor Kerr received the M.D. degree in 1935 from the University of Michigan and interned in Toledo Hospital and at the State Psychopathic Hospital at Ann Arbor, Mich.

DR. STUART P. CROMER, recently assistant medical superintendent of the Research and Educational Hospital, University of Illinois College of Medicine, Chicago, has been appointed superintendent of Baylor University Hospital to succeed **DR. EDGAR M. DUNSTAN**, who is head of the Dallas city and county hospital system.

DR. GEORGE A. JOHNS, who recently resigned as superintendent of the St. Louis Training School, an institution for feeble-minded children, has accepted an appointment as superintendent of the Rosewood State Training School, Owings Mills, Md.

EDITH KAMRATH, formerly superintendent of the Union Hospital, New Ulm, Minn., is the new superintendent of Hutchinson Community Hospital, Hutchinson, Minn., succeeding **ESTHER WOLFE**, who has gone to St. Andrew's Hospital, Minneapolis, as superintendent.

DR. EDWARD MCKEE GOODWIN, seventy-eight, who became superintendent emeritus of the North Carolina School for the Deaf, Morgantown, in May, after serving as directing head of the institution since its opening in 1894, died recently. **DR. CARL E. RANKIN**, assistant superintendent for two years, was elected Doctor Goodwin's successor upon his retirement.

CAROLINE E. DAVIS, of Chicago, has assumed her new post as superintendent of the King's Mountain Memorial Hospital, Bristol, Va.

DR. ERWIN D. FUNK has been serving in the capacity of acting superintendent of the Reading Hospital, Reading, Pa., since the resignation of **JOHN M. SMITH**.

RUTH CLYBORN was formally disclosed as the successor of **P. T. BOWEN**, as superintendent of the Champaign County Hospital, Urbana, Ohio, by the county commissioners. Miss Clyborn formerly was head nurse, and has been in charge of the hospital in her new capacity since July 15, it was revealed. Mr. Bowen has been superintendent of both the county infirmary and the county hospital for the last ten years. He will continue as infirmary superintendent.

NAOMI BEERY, supervisor at Lima Memorial Hospital, Lima, Ohio, has been selected as full-time nurse for Ohio Northern University's first student hospital, opening in September.

DR. MERRELL L. STOUT has been appointed director of the Hospital for Women of Maryland, Baltimore, succeeding **MAUDE GARDNER**, who resigned. Miss Gardner, who is president of the Maryland State Nurses' Association, had held the post of superintendent of the hospital for fifteen years. Doctor Stout is a graduate of the Johns Hopkins Medical School.



Moir P. Tanner

MOIR P. TANNER, assistant superintendent at the Buffalo General Hospital, Buffalo, N. Y., for the last eight years, will become superintendent of the Children's Hospital of Buffalo in September, succeeding **MRS. EVANGELINE J. NYE**, who is retiring because of poor health after twenty-seven years of service.

BEULAH WOOD FITE's appointment

as superintendent of the Fite Hospital at Columbus, Miss., has been announced by her brother, **DR. P. L. FITE**, head of the institution. Miss Fite has resigned her position as juvenile court probation officer. She also has been a field representative for the American Red Cross.

DR. ORR MULLINAX has been re-elected superintendent of Missouri State Hospital No. 2 at St. Joseph. Doctor Mullinax has been superintendent since February, 1935.

MRS. LOIS HOAG has been named acting superintendent for one year of the McKinley Hospital, Urbana, Ill., succeeding **MRS. KATE PUTNAM LARABEE**, who resigned. Mrs. Hoag has been assistant superintendent at the hospital since 1927.

MRS. LOUISE CAMPBELL, head nurse at the Zeigler Hospital, Zeigler, Ill., for the last four years, has been named as the successor to **MRS. LEORA BELDEN**, superintendent of the West Frankfort Union Hospital, West Frankfort, Ill. Mrs. Belden resigned to accept a position as business administrator at St. Joseph's Hospital, Alton, Ill.

DR. PAUL COHN assumed the duties of superintendent of the Eastern Shore Branch, Maryland Tuberculosis Sanatorium, at Salisbury, Md., recently, succeeding the late **DR. CHARLES D. STENKEN**.

DR. CLARENCE WELLS has sold the Sequoia Hospital, Woodlake, Calif., constructed less than two years ago, to his assistant, **DR. ROY S. RUTH**, for \$20,000.

DR. ROY W. GOSHORN, Bellwood, Pa., has been appointed superintendent of the Blair County Hospital for Mental Diseases, Hollidaysburg, Pa., to succeed the late **DR. HENRY J. SOMMER**.

DR. GEORGE T. McMAHON of Burnett, Tex., has been named superintendent of the new West Texas Hospital for the mentally ill, to be located by the board of control at an early date. Doctor McMahon will take up his duties at once, and work with **DR. CHARLES W. CASTNER**, chief of the eleemosynary division, in planning for the construction and opening of the new hospital.

SADIE CHEELY, R.N., a graduate of the Petersburg Hospital, Petersburg, Va., who has been operating room superintendent there for some time, has been selected as superintendent of the new John Randolph Hospital, Hopewell, Va. Miss Cheely succeeds **VIRGINIA BUSH**, who has resigned to be married.

RUTH J. ADIE, formerly superintendent of the Malden Hospital at Malden, Mass., has been appointed superintendent of the Chenango Memorial Hospital, Norwich, N. Y., succeeding the late **MARY UNDERWOOD**. Prior to her last position, Miss Adie was superintendent of the city hospital at Barre, Vt., and assistant superintendent and later superintendent of the city hospital in Quincy, Mass.

First Aid to Hospitals

For the hospital suffering financially from too-rapid growth, inadequate equipment or falling revenues there is today a tried and proved remedy. Haphazard methods of raising money no longer suffice in this highly specialized field.

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The 1937-1938 fund-raising season is at hand. Make your plans before it is too late. Delay may result in the preemption by others in your community of both time and opportunity. An experienced member of our staff will be glad to discuss your problem with you, without obligation. Write us today.

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CONTRACT DEPARTMENT

• ALBANY, N. Y.

G. MARIE BAKKE has been appointed superintendent of the Spencer Hospital, Spencer, Iowa, succeeding RACHEL STERLING, who resigned. Miss Bakke is a former superintendent of the Vermillion County Hospital, Clinton, Ind., and of the McPherson Memorial Hospital, Howell, Mich.

DR. ALFRED J. NORMAN will retire October 1 as assistant superintendent of the San Francisco Hospital after thirteen years of service. His position will be filled through civil service examination by a business manager for the institution, according to a plan advanced by DR. J. C. GEIGER, public health director, and DR. LELAND M. WILBOR, hospital superintendent. The business manager will have charge of the purchasing and business end of the hospital, which cares for 1,100 patients a day at an annual expense of \$1,500,000.

MRS. SADIE J. O'BRIEN, who has been superintendent of nurses at the Harlem Hospital, New York City, since she organized the school of nursing there in 1923, died at the hospital recently following a brief illness.

DR. ROLAND A. DAVISON has been appointed to succeed DR. LOUIS C. B. Baldwin as medical director of the Desert Sanatorium, Tucson, Ariz., at the expiration of the latter's term next fall. Doctor Baldwin is returning to private practice.

DR. MITCHELL P. WARMUTH died recently at National Stomach Hospital, Philadelphia, of which he was a founder.

MRS. HENRIETTA R. MUIR has resigned her post as superintendent of nurses at the Los Angeles General Hospital.

DR. JOHN N. ALLEY, superintendent of Tacoma Sanatorium, Tacoma, Wash., operated by the U. S. Department of the Interior, has retired from that position and has been appointed to the staff of the Eastern State Hospital, Medical Lake.

MADELEINE MCCONNELL, graduate nurse of St. Luke's Hospital, Chicago, is the new executive secretary of the Illinois State Nurses' Association. Miss McConnell has been attending the Yale School of Nursing at New Haven, Conn.

MURIEL O'BRIEN, a graduate of the University of Alberta with one year's internship in the University of Alberta Hospital, has been named dietitian at Vegreville General Hospital, Vegreville, Alta. MARGARET LIPSEY, another graduate of the University of Alberta, having had the same internship, has been appointed dietitian at Lamont Public Hospital, Lamont, Alta.

DR. CHARLES FREDERICK WILLIAMS and DR. JAMES LAWRENCE THOMPSON have been honored by having two buildings named for them at South Carolina State Hospital, Columbia.

FLORENCE MONAHAN, managing officer of the Illinois School for Girls, Geneva, Ill., has resigned to take a similar position in California.

MARGARET HUGHES, who recently completed the course in medical records at St. Mary's Hospital School for Medical Record Librarians, Duluth, Minn., has secured a position as chief record librarian at St. Joseph's Hospital, Denver.

MRS. JOSEPHINE NICHOLS POST has been appointed superintendent of nurses at the Jefferson Davis Hospital, Houston, Tex.

DR. DANIEL W. COUGHLAN has been appointed clinical supervisor at the Broadlawns, Polk County Public Hospital, Des Moines, Iowa.

EDITH M. LACEY of the University of Minnesota has taken charge of the Hudson City Hospital School of Nursing, Hudson, N. Y.

MRS. BEUNA FOGG FARRAR is retiring as supervisor of the maternity division at Norfolk General Hospital, Norfolk, Va.

MARIAN E. KALKMAN, formerly educational director at the school of nursing, Worcester State Hospital, Worcester, Mass., recently was appointed superintendent of nurses at the State Psychopathic Hospital, Ann Arbor, Mich.

WINTRESS DALBEY, Danville, Ill., recently accepted a position as dietitian at the Veterans Administration Hospital, Danville.

FRANCES MILLER has been appointed chief medical record librarian at St. Luke's Hospital, St. Paul, following her recent completion of the course in medical records at the St. Mary's Hospital School for Medical Record Librarians, Duluth, Minn.

IDA MAE LEE, a recent graduate of the St. Mary's Hospital School for Medical Record Librarians, Duluth, Minn., is the new chief record librarian at Decatur and Macon County Hospital, Decatur, Ill.

Voluntary Hospital Fined for Refusing Charity Case

Lake View Hospital, Chicago, which has gained much unfavorable publicity over refusal to accept a charity patient wounded in a gun battle, was fined \$50 in Felony Court recently for failing to give treatment other than first aid. The complaint brought at the hearing was based on a state law requiring hospitals to give suitable medical aid to any emergency patient regardless of his ability to pay.

The hero of a gun fight was taken to the Lake View Hospital where three wounds were cauterized and treatment was given to stop bleeding. He was later removed to the Cook County Hospital because no fee was assured.

The Lake View Hospital is now involved in bankruptcy proceedings in the federal courts, and payment of or appeal from the \$50 fine must be approved there.

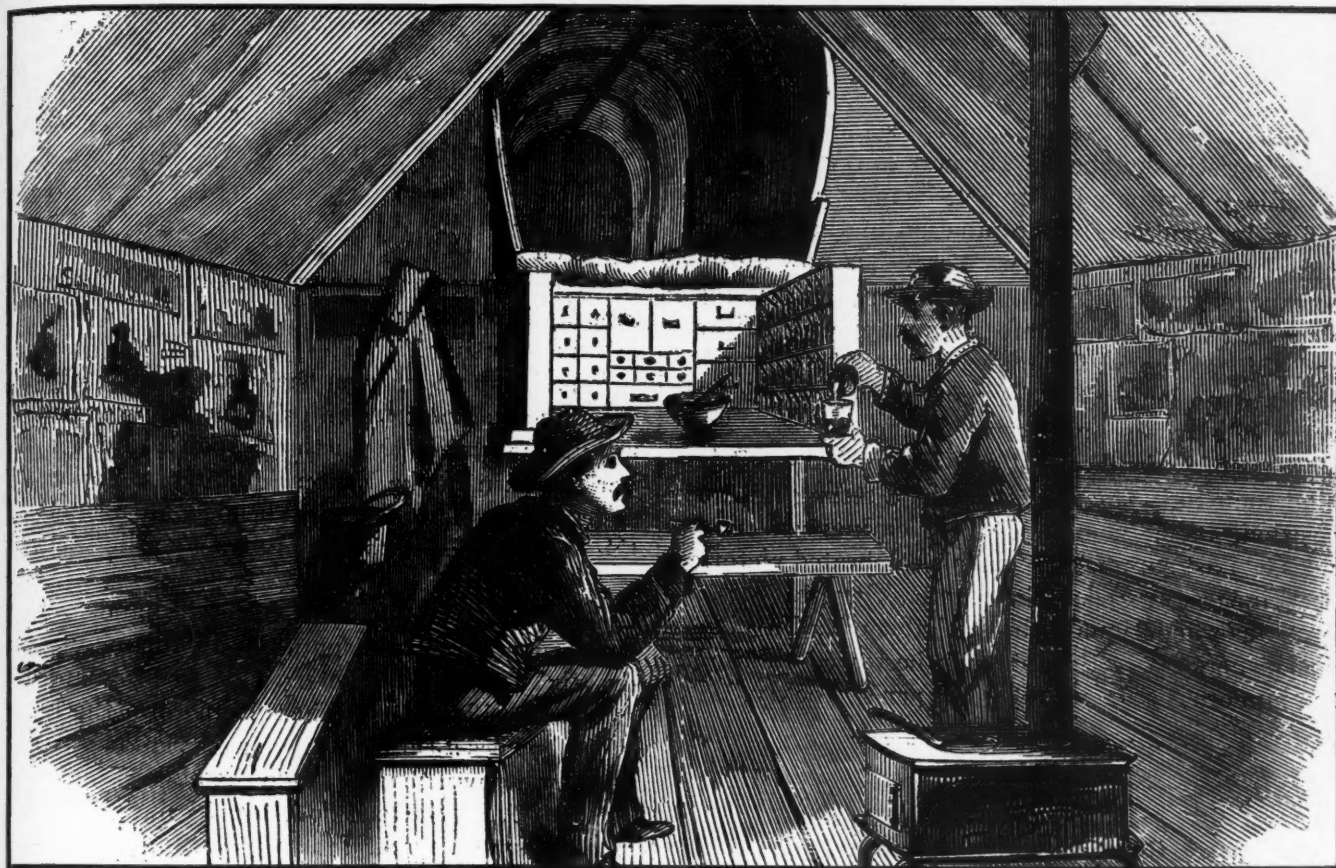
In New York State a conflicting decision was handed down by Attorney General John J. Bennett, Jr., in considering a complaint that certain hospitals had declined to receive victims of automobile accidents. The attorney general said that municipal hospitals were required by state law to care for patients regardless of their ability to pay, but that private and voluntary institutions were not subject to any such statutory obligation. David H. McAlpin Pyle, president of the United Hospital Fund, which includes all larger institutions except municipal hospitals, said that members of the fund would continue to give service to emergency patients regardless of the ruling.

Meanwhile in Washington, Senator James Hamilton Lewis recently introduced a proposal which would require all physicians, surgeons and hospitals to care for impoverished individuals at "reasonable and just" charges, to be paid through the Social Security Board. The Illinois senator addressed the house of delegates of the American Medical Association at Atlantic City on June 10, saying that physicians soon must consider themselves as officers of the federal government and that they might be licensed by the government as they are now licensed by the states. However, President Roosevelt denied that he was considering a plan for federalized medicine.

Coming Meetings

- Hospital Institute.**
Next meeting, University of Chicago.
Aug. 30-Sept. 10.
- Canadian Hospital Council.**
Next meeting, Ottawa, Sept. 8-9.
- National Association of Nurse Anesthetists.**
Next meeting, Atlantic City, N. J.,
Sept. 14-16.
- American College of Hospital Administrators.**
Next meeting, Atlantic City, Sept.
12-17.
- American Hospital Association.**
Next meeting, Atlantic City, Sept.
13-18.
- American Protestant Hospital Association.**
Next meeting, Atlantic City, Sept.
10-12.
- Children's Hospital Association.**
Next meeting, Atlantic City, Sept.
13-17.
- Southern Tuberculosis Conference.**
Next meeting, Richmond, Va., Sept. 29-
Oct. 1.
- American Public Health Association and
National Organization for Public
Health Nursing.**
Next meeting, New York City, Oct. 5-8.
- Saskatchewan Hospital Association.**
Next meeting, Regina, Oct. 10.
- American Dietetic Association.**
Next meeting, Richmond, Va., Oct.
18-21.
- Ontario Hospital Association.**
Next meeting, Toronto, Oct. 20-22.
- American College of Surgeons.**
Next meeting, Chicago, Oct. 25-29.
- Association of Record Librarians of
North America.**
Next meeting, Chicago, Oct. 25-29.
- Kansas Hospital Association.**
Next meeting, Newton, Oct. 30.
- Colorado Hospital Association.**
Annual convention, Denver, Nov. 9-10.
- Alberta Hospitals' Association.**
Next meeting, Edmonton, Nov. 15-17.

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LITERATURE in ABSTRACT . . .

Conducted by E. M. Bluestone, M.D. and Joe R. Clemmons, M.D.

Food Costs

It is a false idea to regard a knowledge of costs as the end rather than the means to an end in the restaurant business.*

The roots of real efficiency and low food costs in the restaurant are to be found in a few basic principles:

1. Each employee should have a basic understanding of the job assigned to him and the value of food.

2. The menu should be timed so that patrons get their food as freshly cooked as possible. This method is of advantage to the pocketbook of the restaurant as well as to the appetite of the patron. Cooking in small quantities is a great factor in the prevention of waste.

3. The menu should be so organized that the kitchen will be keyed to peak efficiency at the meal hour. The planner has to consider just how each dish is prepared in the kitchen so that no particular section, such as range top or oven broiler, is loaded to the point at which efficiency is impaired at a time when smoothness of operation is most needed.

4. In order to proportion out from the storeroom only what the recipes require, all recipes should be standardized. This helps keep oversupplies out of the kitchen and also aids employees in maintaining a rational sense of the value in food.

5. It is wise also to buy no more than is needed, particularly with respect to perishables.

Whatever the system of method employed, there is always plenty of leeway for the application of good, hard common sense in almost every phase of restaurant operation.

*Stiles, H. E.: *Coordination of Efficiency and Food Costs*, Am. Rest. April, 1937. Abstracted by Ida D. Winaker.

Digest of the Wagner Act

The purpose of the Wagner Act is to encourage the procedure of collective bargaining and to protect the rights of workers in self-organization. Employers are subject to the act only when (1) they are engaged directly in interstate commerce, or (2) when the interruption of employer-employee relations will have such a direct and immediate effect on interstate commerce as to obstruct or interfere with or burden the free flow of interstate commerce. Each case must be decided on its own facts. Where the courts will draw the line as to what is inter-

state commerce is purely conjectural at this time. Clearly, the act does not apply to purely local businesses, such as hotels, office buildings, strictly retail stores, and service industries.*

Five unfair labor practices are prohibited on the part of employers:

1. No employer shall interfere with, restrain or coerce employees as to self-organization and collective bargaining.

2. No employer shall dominate or interfere with the formation or administration of a labor organization, or contribute financial or other support to it, provided that, subject to certain rules of the Labor Board, an employer is not prohibited from permitting employees to confer with him during work hours without loss of time or pay. Whether the attempt to dominate is successful or otherwise, the attempt has been held to be a violation of the prohibition.

This, however, does not mean that the employer is restricted from talking to his employees, either individually or collectively, in order to explain to them frankly and exactly the rights and powers of both employees and employers under the act.

3. It is unlawful for an employer to discriminate in regard to any term or condition of employment in order to encourage or discourage membership in any labor organization, provided any employer may agree with a labor organization to require membership in such organization as a condition precedent to employment, if such organization is the representative of the employees. This does not interfere generally with the freedom of an employer to hire or discharge as he pleases, provided that he may not use such power in such a way as to foster or hinder the growth of a labor organization. An employer may employ anyone or no one. The employer has the full right to limit the access to the premises to the employees. Temporary lay-offs or furloughs, when discrimination is utilized, have the same effect as a discharge or refusal to reinstate because of union activities. It should be noted that nothing contained in the act prohibits or interferes with the right of an employer to maintain an open shop.

4. No employer shall discharge or otherwise discriminate against an employee because he has filed charges or given testimony under the Wagner Act.

5. It is unlawful for an employer to refuse to bargain collectively with the representatives of his employees. The

Labor Board has construed this to mean that the effort at collective bargaining must be real, and not merely apparent. The Labor Board has held that collective bargaining means that the parties must act in good faith, and with a serious intent to adjust differences and to reach an acceptable common ground. The board has held that bargaining with individual employees who are members of a union is a violation of this unfair labor practice. The employer is under a duty to bargain collectively during a strike, since employees do not cease to be such because they have gone out on strike.

When the majority of employees have once determined their proper bargaining representatives, the employer is under duty to bargain with such representatives, and such representatives have the right to represent all employees in bargaining as to wages, hours and working conditions. This does not preclude the right of individuals or minorities to present to the employer and discuss grievances with him. However, the employer may enter into individual contracts of employment. The employer is not obligated to execute a contract. Bargaining in good faith alone is required. If a plant association has the majority of employees and its elected representatives make a contract with the employer, that contract is binding and outside organizers have no standing in bargaining with the employer for his employees.

*Borders, M. L., Jr.: *A Digest of the Wagner Act*, Skyscraper Management 22:10 (June) 1937. Abstracted by Louise Large.

Salaries of Public Health Nurses

Data furnished by 449 agencies employing 8,228 public health nurses and insurance companies employing 711 nurses showed an average salary of \$125 per month paid to nurses in various staff positions.* Sixty-eight per cent as compared to 59 per cent in 1936 were receiving more than \$125. More than half of this group received \$150.

In cities of one million or more population the prevailing salary was \$150 per month; in the smaller cities, \$115. Median salaries were higher in the large cities and decreased according to the size of the community, and increased again in cities of less than 50,000 population and in rural areas. In the larger private agencies, \$150 per month was the usual staff salary; in organizations of less than 100, \$125 per month; in one-nurse services, \$150 per month. These averages were exceeded in New England, the Middle and Far West.

The median salary of private agencies for the country as a whole was \$123 per month; in the South, \$112.

The median salary of supervisors in both the private agency and public

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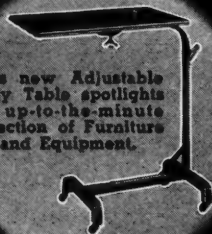


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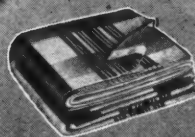
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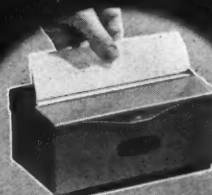
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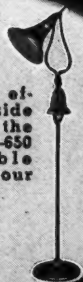
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health departments was higher this year, \$155 per month as compared to \$152 and \$171 per month to \$168, respectively.

Twenty-five private agencies and five health departments reported educational directors. In the former the minimum salary was \$135 per month, the median \$185 and the maximum \$265 per month. The median salary of the director and assistant director of nursing increases with the size of the organization. In the private agencies it was \$193, and in the health departments, 178 per month.

The average annual salary of school nurses was \$1,800 as compared to \$1,700 last year. More than one-third received more than \$1,800, the maximum represented being \$2,900. In the Far West more than one-half received \$1,800 or more. In the South all were below \$1,700.

Forty-four boards of education reported nurse directors. The salaries varied from \$1,250 to \$4,600 a year.

In 1937 approximately 40 per cent of both private agencies and health departments were at pre-cut levels. This is true of nurses in only 22 per cent of the boards of education.

Definite schedules of salaries specifying the minimum with automatic increase to a maximum were in effect in 39 per cent of private agencies and in 23 per cent of health boards studied. The maximum was reached in three and two years, respectively.

Salary schedules were in effect in 46 per cent of boards of education. The period required to obtain the maximum ranged from two to seventeen years.

In 25 of 87 private agencies salary schedules were modified for nurses who on appointment had had further preparation than the minimum requirement. This was not true in health departments.

When some course is required for both the private agency and the health department, the minimum offered at the start is \$100. Analysis of similar information indicated that the minimum salary offered by the department which requires a public health nursing certificate was higher than those who did not.

*Miller, Anna J.: Salaries of Public Health Nurses, 1937, *Pub. Health Nurs.* 29:368 (June) 1937. Abstracted by J. R. Clemmons, M.D.

Aseptic Rays

The author* has made a thorough investigation of the cause of operating room infections, which he found to be due to *Staphylococcus aureus* (usually hemolytic) in 90 per cent of cases. After elimination of all possible causes such as the skin of the patient, the operator's hands, linen, instruments, sponges, solutions, gloves and catgut, he came to the conclusion that the infection was air borne.

Careful studies showed that the con-

tamination of the air occurred from the nose and mouth of the operating room personnel; and that the amount of contamination was definitely dependent upon the number of people in the operating room, the duration of occupancy and the time of year.

In spite of careful masking, elimination of known *Staphylococcus* carriers in the personnel and control of the air currents in the operating room, infections still occurred. The use of radiant energy was then tried in order to sterilize the air around the operating table. Eight tubes, each 30 inches in length, were incorporated in the operating room light. A wave length was found that was germicidal in thirty seconds to a heavily sprayed culture. The wave length used caused only a slight erythema in a blond person after eighty minutes' exposure, so that the tubes could be kept on during an operation and the personnel protected by masks, gowns, gloves and goggles of plain glass.

Experiments showed no injury to the operated tissues and no tendency to cause peritoneal adhesions, and cultures showed the air near the operating field to be sterile.

Patients had less postoperative pain, healing was more rapid, there was little rise of temperature. In approximately fifty operations with large incisions there have been no infected wounds and all cultures of material from the wounds have shown no growth.

This is a preliminary report on the use of special radiation tubes for the control of air borne organisms, and is suggested as an added method for the attainment of the 100 per cent aseptic operative technique.

*Hart, Deryl, M.D.: Bactericidal Radiant Energy for the Operating Room—Operation Room Infections, *Arch. Sur.* 34:874, 1937. Abstracted by A. H. Aufses, M.D.

Vocational Diagnosis

The need for vocational guidance, not only during the adolescent period, but also in adult life, to prevent maladjustment and guide workers into the field of activity to which they are best adapted, is increasingly recognized in modern organizations. A program of diagnosis and guidance along these lines has been developed by one unit of the Pennsylvania State Emergency Relief Administration*, within its own social service staff with a three-fold purpose:

1. To discover employees giving promise of possible adaptability to executive positions.
2. To acquaint employees with their defects and supply them with a technique of self-improvement.
3. To discover and readjust definitely unsatisfactory workers.

This program was carried out by, first, evaluating employees by a series of tests, including job performance,

and technical knowledge; followed by a personal study of defects and their correction, and, finally, achievement tests, to ascertain progress. Once completed, these tests and procedures were made available to other relief groups.

*Adams, C. R., and Smeltzer, C. H.: Guidance in a Relief Organization, *Occupations*, Pp. 636-637. (April) 1937. Abstracted by Celia M. Pearson.

Fish Preferences

A survey on fish in 64 hotels and restaurants* showed filet of sole to be the most popular, being so designated by 18; next came whitefish mentioned by 8; scrod, 6; halibut and pike, 4; broiled mackerel, 3; bluefish, broiled lobster, sauté sandabs, sea bass and trout, 2; boneless shad and roe, broiled red snapper, codfish cakes, deviled stuffed crab, filet of haddock, flounder, salmon, sea food platter, tuna fish salad and Virginia spats, 1.

*What America Is Eating, *Hotel Man*, April, 1937. Abstracted by Helen Lubach.

Work for the Handicapped

The greater importance of a satisfactory return to self-support in the case of an "arrested" tuberculous patient than in other types of disability is not always recognized. It is, however, a fact that the success or failure of his struggle against depression and fear will be aided or retarded by his economic experiences and thus operate directly upon his physical condition in a way not at all comparable to the effects on those suffering from orthopedic disabilities or blindness.*

There are many difficulties to be faced in the attempt to facilitate the re-entry of the tuberculous into the working world. Among them are the correct choice of a job, retraining for new industries and the overcoming of popular prejudice against those with a record of sanatorium experience.

The United States Employment Service, through its nationwide network of public employment offices, has made special arrangements to care for the handicapped of this type, assuring a specific study of each individual case by well-trained workers and a listing of all possible openings suited to the tuberculous. Recognizing that the greatest asset of a placement service is a satisfied employer, the Employment Service stresses the need for careful selection of all applicants. It does not advocate a separate placement agency for handicapped workers, experience showing that many employers will not use an agency specifically for the disabled and that a competitive attitude between agencies for the handicapped and nonhandicapped would not be desirable.

*Persons, W. Frank: Placement of the Tuberculous, *Occupations*, Pp. 620-623. (April) 1937. Abstracted by Celia M. Pearson.



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*Do you need trained minds, skilful hands,
eager, earnest workers go-getters?*

At night, when a hectic day is done, do you ever sit and wish . . . and wish for the kind of people who'd get things done, in your hospital?

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The fame of hospitals depends upon the work of men and women. If the men and women you have are ordinary, then the fame, the reputation of your hospital is ordinary; for ordinary people can't and won't do fine things.

Ordinary people do ordinary things.

But fine things result when you trust the work of your hospital to a saintly tribe with shining eyes, to a group of men and women who

know that life's too short for the journey, to folks who are eager and earnest, who've a song on their lips that work can't quench.

These are things you know; things that we know. They're the fundamentals with which we work. Our task to find skilful hands, trained minds, eager, earnest workers . . . go-getters . . . for you.

Then, when we've found them, to make equally certain that we place them in positions that they'd love, where they'd willingly, eagerly do the things that must be done as you want them done.

The fame of hospitals depends upon the work of men and women. Tell us the kind you want. Finding them is our great work.

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See Catalog in SWEET'S

BOOKS ON REVIEW

A CLASSIFICATION FOR MEDICAL LITERATURE.

By Eileen R. Cunningham. Second Edition, Revised and Enlarged. Nashville, Tenn.: Cullom and Ghertrner Company. 1937. Pp. 104. \$2.

This scheme evolved by the librarian of Vanderbilt University School of Medicine was first published eight years ago, although the original conception had occurred some ten years previously. Radical physical changes have been made in the second presentation. Formerly referred to as the "Kardex Visible," owing to its arrangement on cards, it has now been issued in book form at a considerable reduction in price and in bulk. The preface states that "no radical changes have been made in the general scheme of the classification, so that those who already are using it . . . will have no reason to make extensive changes." The present table of contents bears out the truth of this statement in that the grouping of subjects remains the same as indicated by the 1929 preface: "first the biological sciences, next the organic systems of the body, and then pathological and clinical subjects. All subjects likely to be of importance in medical libraries but not dealing directly with work in medicine including history, biography and general reference works are grouped in an appendix.

"A capital letter has been assigned to each general division and the next subdivision is indicated by a numeral; this division is subdivided in turn by the addition of a second letter (lower case), and this again subdivided by the addition of a numeral."

As the major headings were rendered visible by the former arrangement no index was considered necessary but for this edition an alphabetic index consisting of the last eleven pages with entries in triple columns has been added. This facilitates the use of the classification and will undoubtedly be welcomed by the users of the "Kardex Visible" as well, whatever their reaction to the current format.—MILDRED JORDAN.

A MANUAL OF OPERATING ROOM PROCEDURES.

By Lucile M. Halverson and Almira W. Hoppe. Minneapolis: University of Minnesota Press. 1937. Pp. 239. \$2.

The "Manual of Operating Room Procedures" is for the most part a compilation of instrument set-ups and draping procedures as employed in the operating rooms at the University of Minnesota Hospital, Minneapolis. The book is divided into five specialty groups of surgery. Under each of the five major groups, the authors have listed the purpose of the operation, the operative position, the preparation and draping of the field, technique and sutures used. It is methodically arranged, well indexed and conveniently bound in a loose leaf effect which facilitates frequent and hurried reference.

The authors apparently realized the need of a manual which would be universally practical, and adaptable to local requirements. Towards that end, they have provided alternating blank pages which may be used to convert the manual of procedures as used in a particular hospital (the University Hospital of Minnesota) into one that will be of some value to any surgical department.

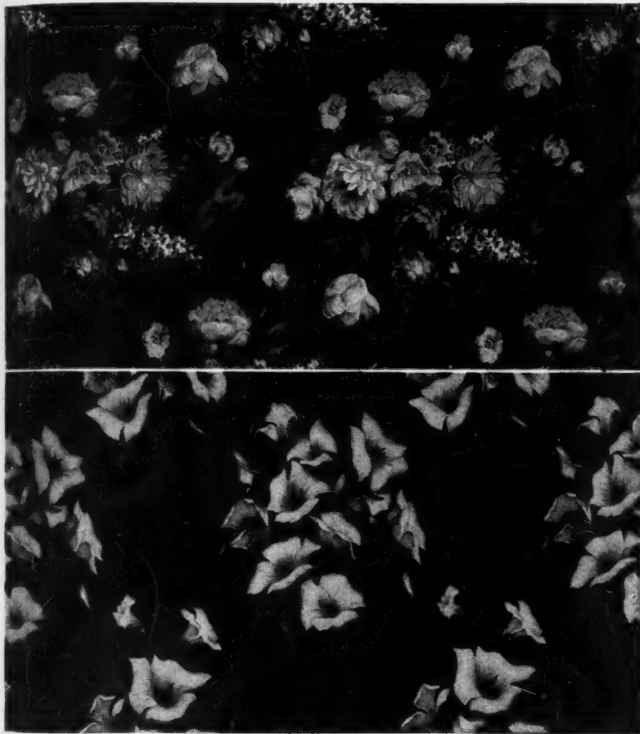
Since the authors have definitely and thoughtfully added to the usefulness of the manual by adding alternating blank pages, one wishes they had included more material

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in Parts I and II under daily routines, materials, preparation and equipment. One also wishes that some illustrations had been included and that such important items as principles of sterilization, preparation of solutions and points of aseptic and antiseptic technique had been given some consideration.

The manual should be of interest and value to all who are concerned with the establishment, revision, or modification of operating room procedures as they apply to the purpose of the operation, operative position, draping, technique (in relation to the actual steps of the operation), instruments and sutures used for each particular operation.—MARIE V. DOWLER, R.N.

THE SOCIAL COMPONENT IN MEDICAL CARE. A study of one hundred cases from the Presbyterian Hospital in the City of New York. By Janet Thornton and Marjorie Strauss Knauth. New York City: Columbia University Press. 1937. Pp. 400. \$3.

Miss Thornton and Doctor Knauth here answer what has long been an urgent need for a clear definition of what constitutes the social component in medical care. Doctor Knauth speaks from the viewpoint of the physician and Miss Thornton as a social worker.

Physicians and hospital administrators should turn with pleasure and relief to their clearly written and well presented analysis of "the part played by social and economic factors in causing loss of health and in hindering recovery from illness." Medical social workers will find in the book a neatly bound answer to that difficult question with which they are so often confronted, "Now tell me, just what is it you do in the hospital?"

Other physicians and hospital administrators will agree with Dr. Walter W. Palmer in his statement in the foreword that "The questions may well be asked: Is there need for social service in the hospital from a purely medical standpoint? Furthermore, is the expense of maintaining such a staff warranted?" To both of these questions the book presents clear and objective answers. There is detailed and critical analysis of the relationship between medical, social and economic problems in cases illustrating acute, recurrent and chronic illnesses. There is, also, clear presentation of the cases in which social and economic factors were found to have had no effect upon the medical problem.

It is refreshing to find an analysis of any professional field so free from any attempt to "sell" the profession as is this. The case summaries, both medical and social, are clearly written and interesting and, for readers interested in forming their own conclusions, there is an appendix containing abstracts of each of the 100 cases from which the material in the book is drawn.

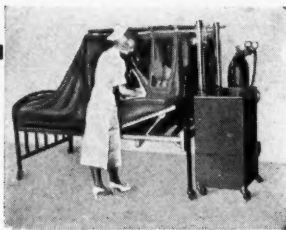
This book should be valuable as a reference in schools of medicine and nursing, as well as in the library of everyone concerned with the relief of illness and physical disability.—EDNA NICHOLSON.

THE HOSPITALS YEARBOOK, 1937. Issued under the auspices of the Joint Council of the Order of St. John and the British Red Cross Society and the British Hospitals Association. R. H. P. Orde, editor. Central Bureau of Hospital Information, London. n.p.

Once again the British Hospital Association has published an excellent review of the hospital year. Of special interest to American readers will be the sections on taxation of hospitals, the care of traffic accident cases and the financial review, the last contributed by Sir Charles Harris.

In view of the present discussion of the eight-hour day for nurses, American readers will be much interested in a

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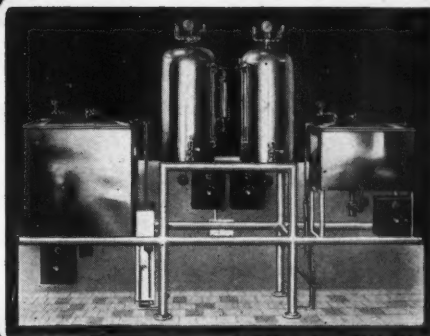
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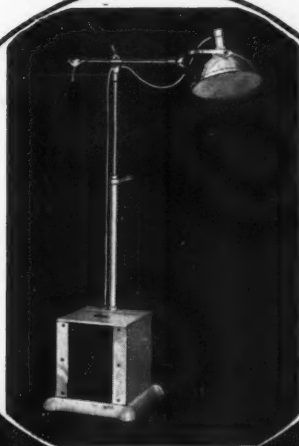
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If you have a Finnell machine which is ten years old or older, please write us at once giving the model number, the date purchased and any other data available that will verify the age of the machine. All entries in this contest must be in Elkhart by Sept. 7, 1937.

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We hope to have the oldest machine—the winner of this contest—on display at our exhibit at the convention of the American Hospital Association, in Atlantic City, September 13-17. Our Booth number is 209. The winner will be announced there and, if possible, the oldest machine will be displayed.

No skill or luck is needed for this contest. There is nothing to judge. It's just a question of dates. The oldest Finnell wins a brand new Finnell of corresponding size. Submit your entries at once! Address FINNELL SYSTEM, INC., 1409 East St., Elkhart, Ind.

FINNELL

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memorandum included in the yearbook which shows that the hours of staff nurses in thirteen representative provincial hospitals vary from 49½ to 60 in the daytime and from 48 to 71 at night. For probationers the corresponding figures are 51½ to 61 in the daytime and 48 to 79 at night.

Much attention is given in the yearbook to the recent report of the Voluntary Hospitals Commission which was reviewed in *The MODERN HOSPITAL*.—ALDEN B. MILLS.

MATERNAL CARE. By Fred L. Adair, M.D. Chicago, Ill.: University of Chicago Press, 1937. Pp. 93. \$1, or, paper bound, \$0.25.

This little volume of ninety-three pages is edited by Dr. Fred Adair. It bears the stamp of approval of the American Committee on Maternal Welfare, and is the handiwork of Doctors DeNormandie, Danforth and Kosmak as well as the editor.

The book is designed especially for the doctor who must do his work in modest homes. The style is clear and concise. The entire field is covered in a surprisingly thorough manner for so small a book.

Each of the sections, prenatal care, intranatal care and postnatal care, is given about equal space, thus placing more than the usual emphasis on the prenatal and postnatal phases of the subject.

There is presented a somewhat formidable system of record keeping, which would seem rather discouraging to the family doctor. Ten pages are devoted to history taking and the first examination. Then follows instruction in subsequent oversight of the patient. The discussion of the diet and hygiene of pregnancy is sound and conservative.

The section on intrapartum care is a brief review of the principles of asepsis, with a short description of methods for their application in the home. The authors say, "Most fatalities are associated with the delivery itself. If antepartum care is followed by inadequate delivery care, results are no better than if no antepartum care had been given." Concise statements of the indications and contraindications for forceps and version are given, with a short description of the technique of these operations.

The section on postpartum care is, in the opinion of the reviewer, especially valuable. The description of minor postpartum complications, to be looked for at the office follow-up and the advice as to management and treatment of these conditions contain information not readily accessible elsewhere. It tells exactly what to look for and what to do about it.—A. J. SKEEL, M.D.

GASTROSCOPY—*The Endoscopic Study of Gastric Pathology.* By Rudolph Schnidler, M.D. With Index and Foreword by Walter L. Palmer, M.D. Chicago: The University of Chicago Press, 1937. Pp. 343.

In the first and third of this volume's twenty-one chapters the history of the gastroscope, together with the technical, optical and practical problems incident to the direct inspection of the stomach, is interestingly discussed.

Chapter II is given over to a description of the anatomy of the pharynx, esophagus and stomach. In Chapter IV a highly illuminating discussion of the technique of gastroscopy is set down. The remainder of the volume is devoted to the pathology and symptomatology of gastric diseases. It is here pointed out that early inspection of the stomach by the gastroscope makes possible the detection of pathology there often long before definite symptoms of ulcer or neoplasm appear and hence favors early treatment.

An atlas with superb cuts in color of the appearance of the normal gastric mucous membrane and that which is diseased concludes this volume.—JOSEPH C. DOANE, M.D.

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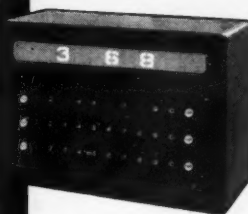
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NEW PRODUCTS...

Sneezers' Solace

One of the annoying things about that annoying mal-
ady, hay fever, is that it is hard to make anyone who
doesn't suffer from it realize how truly uncomfortable it is.
The tearful eyes and red nose that characterize the sea-
sonal sneezer seem to strike nonsufferers as funny.

A few people there are, sufficiently sympathetic to have
devoted years to discovering ways of combating the dis-
ease. One of the most interesting of new devices designed
for this purpose is the electrostatic precipitator. (Try
saying that between sneezes.) This portable air cleaning
machine operates on a new principle by which, it is said,
practically all smoke, dust, pollens and other impurities
are removed from the air. It consists of two major parts:
the ionizing chamber and the collector plates. As air
passes through the machine it is first drawn into the
ionizing chamber. Every particle of foreign matter in the
air receives an electrical charge as it passes through this
chamber. The collector plates are also electrically charged.
As the air flows from the ionizing chamber through the
collector plates, these particles are drawn to and deposited
on the plates by electrostatic force, just as a needle is
drawn to a magnet. Thus, 99½ per cent of the impurities
in the air are deposited on the collector plates.

Inasmuch as dust, smoke, pollen and other air-borne
particles are known to be among the causes of various
disorders of the respiratory tract, the manufacturers feel
that the air cleaner should be of interest to the medical
profession.

The precipitator is manufactured by Westinghouse Elec-
tric & Manufacturing Company, East Pittsburgh, Pa., and
distributed by the Atmospheric Electric Filter Corp., 233
Broadway, New York City.

Porker's Rest

A fitting climax to the career of the haughtiest cham-
pionship porker would be to rest in peace within one of the
ultramodern refrigerators that have been pridefully an-
nounced by the McCray Refrigerator Company of Kendal-
ville, Ind. Indeed, could Mister Pig see his chops reflected
in the black porcelain floor of Model RF-418, he would be
reconciled to his fate.

Anyway, the McCray Company feels sure that this latest
model will arouse enthusiasm among dietitians, for it is
especially suitable for use in the diet kitchen. The re-
frigerator is finished inside and out in white duralite with
black base and trim. Two service doors give access to the
interior, which is fitted with six metal bar shelves and has
a capacity of 18.7 cubic feet. Automatic electric lights are
operated by a door switch.

The refrigerator is ready to plug into any lamp socket
and start humming, being equipped with special coils and
compressor. It is insulated with 3 inches of corkboard
sealed with hydrolene. All doors are fitted with double
pneumatic gaskets.

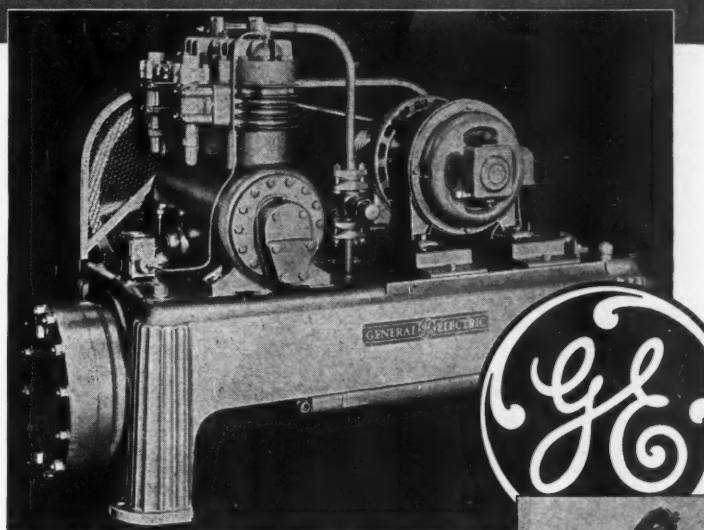
Continued Heat Wave

Gastronomically speaking, there are two classes of peo-
ple only: those who live to eat and those who eat to live.
Patients in hospitals, for the duration of their illness, at
least, generally come into the latter category. Even so,
the eating ought to be good. (Cont. on page 128)

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REFRIGERATION service is only as good as its mechanism. Expensive, old-fashioned apparatus may be costing you more than to buy and operate new General Electric "Scotch Giant" refrigerating machines. Built to provide a greater measure of long-life, attention-free, low-cost refrigeration service. And, *prices now are lowest in history!*

If your refrigeration equipment is over five years old, it's good business to have it examined. A factory-trained G-E engineer will make a free survey of your system. If there's anything wrong he will show you how to correct it . . . how you can save money by eliminating excessive maintenance and repair bills . . . how to get better refrigeration service at less cost. Phone your General Electric distributor—ask him to send over a refrigeration specialist. Or write General Electric Company, Commercial Refrigeration Division, Section CX9, Nela Park, Cleveland, Ohio.

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The sensational G-E "Scotch Giant" refrigerating machines . . . available in all sizes for all requirements . . . are rugged, powerful, dependable, thrifty!



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THOSE LITTLE BLADES TRAVEL 10 MILES EVERY HOUR

—and they work every inch of the way. That is why builders of pumps need experience. The little rotary pumps in Wocher-made units are precision instruments. An error of .001" in machining could ruin the pump. Improper choice of materials for fast-moving parts would shorten life.

Wocher engineers know how to design these products and Wocher skilled machinists know how to build them right.

WO8137 Yale Air, Suction and Ether Unit (above) is a complete equipment for major surgery. Explosion-proof motor, twin pumps and all necessary equipment. The price is two hundred and seventy-five dollars.

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MONT R. REID TABLES—RIES LEWIS LIGHTS

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Cincinnati, Ohio

Among the numberless people daily occupied with the problem of improving this country's eating habits is the Standard Gas Equipment Corporation, 18 East 41st Street, New York, which lately has been bending its efforts toward making bake ovens do bigger and better bakings. These efforts have been amply rewarded by the latest achievement: a new multiple heat conduit bake oven. It is so called because of the construction of a number of flues which direct the flow of heat to all parts of the oven instead of letting it go where it will. The manufacturers say that this oven has unsurpassed baking qualities, largely because of those same multiple heat conduits, and that it turns out a superior quality of baked goods.

The oven is made in sections so that any combination of baking or roasting oven can be made up, each of which has its own heat control.

Floodproof

When the Father of Waters goes into his spring tantrum, it is a problem for those in the vicinity to keep from getting wet. Witness the devastating dampness that recently permeated Indiana, Kentucky and Southern Illinois. In such cases a waterproof building can be counted among the greater blessings, and that there is such a thing we are earnestly assured by the Truscon Laboratories of Detroit. Calking is the secret of it all, and Truscon is pleased to present in a new brochure entitled, "Buildings of America," a calking compound that prevents buildings from springing embarrassing leaks.

The compound is so formulated, we are told, as to dry with a tough, air-tight film, leaving the material underneath in a plastic, flexible condition that expands and contracts with the movement in the structure. It adheres tightly to the walls of an opening, bridging them with a waterproof, air-tight, nonstaining calk which will not shrink away from the joint or crumble. For further technical details, ask Truscon for the brochure.

Edge Wise

It may be small comfort to the surgical patient to know that, no matter how tough his texture, the knife that the surgeon wields upon him will be as sharp at the end of the operation as it is at the beginning.

But if the layman can't appreciate the finer points of surgical blades, the American Safety Razor Corporation of Brooklyn, N. Y., knows that surgeons will appreciate a knife that will exert the same cutting pressure all through the operation. This company has brought out some new blades that have the extra strength, durability and keenness that will enable them to last double the length of an ordinary surgical intervention.

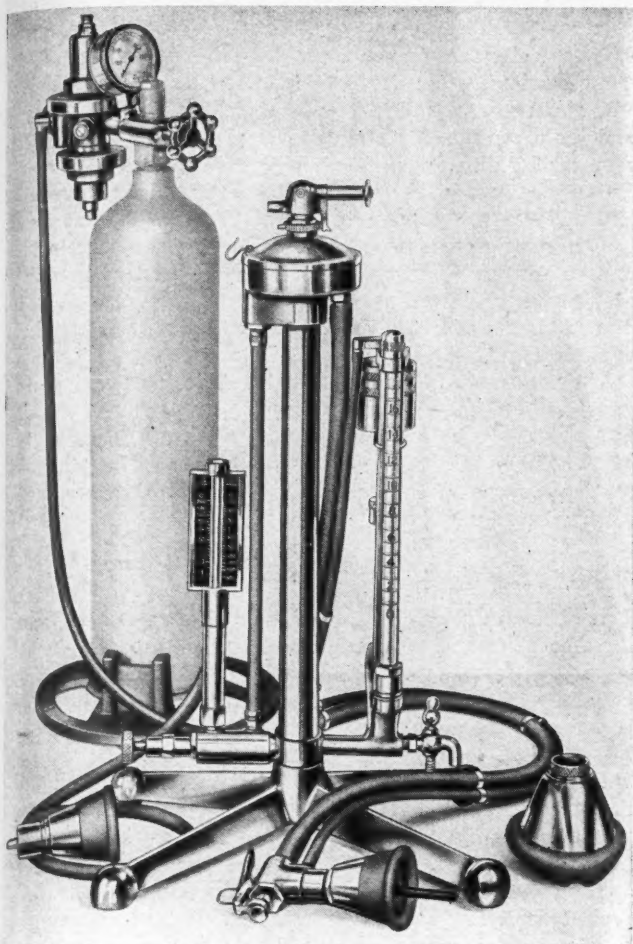
Because a knife without a handle is no knife at all, this manufacturer offers an improved handle designed for perfect balance and operating ease.

Limbering Up Baby's Lungs

The bitter yell of protest with which any normal baby heralds his arrival on earth is music to the ears of the doctor as well as his palpitating parents, meaning as it does that Mr. Baby has the lung power with which to whoop. His failure to express himself, on the other hand, indicates a lack of ability to clear his lungs and at this point the resuscitating apparatus goes into action.

The resuscitation of new-born infants has evolved slowly from the old mouth-to-mouth method, through various stages down to the mechanical resuscitator. In a recent issue of the *Journal of the American Medical Association*, Dr. D. Ben Martinez of Pittsburgh arises to remark that

WE ANNOUNCE



The Heidbrink RESUSCITATOR and INHALER KREISELMAN MODEL

An apparatus which functions to accomplish the safe, convenient administration of resuscitative gases to still-born infants and to all patients whose breathing has ceased or is depressed, to create normal breathing for the former and restore it for the latter.

The Resuscitator and Inhaler has been offered to the profession only after careful research and study, and has built into it the scientifically accurate and dependable quality and the many exclusive features that have made all Heidbrink apparatus the recognized standard. Comes in Portable Models, Stand Models, Cart Models, and Electrically warmed Bassinet Models.

Our advance Bulletin giving prices and details will be sent upon request.



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Assuredly, the scrub up room is no place for penny pinching. The soap and dispensers your doctors use are just as important to them as rubber gloves and instruments. Nothing but the best will satisfy.

That is why more than 60% of America's hospitals use Germa-Medica—dispensed from Levernier Foot Pedal Dispensers*. Because Germa-Medica Liquid Surgical Soap is dependable. Its energetic, detergent olive-oil lather not only dissolves dead tissue and removes bacteria, but it does so without irritating the most tender skin.

Once and for all you can end scrub up complaints by using Germa-Medica in Levernier Dispensers. Your doctors will welcome the change.

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HOSPITAL DIVISION

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LABORATORIES Inc.**

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his experience, of 500 cases, with the E & J Resuscitator (E & J Company of New York, 101 Park Avenue) has led him to the conclusion that this apparatus is a definite life-saving device and should be a part of the armamentarium of all hospitals caring for obstetric patients.

It is a positive and negative apparatus and the pressure is exerted by the oxygen over the baby's face through a mask similar to that used in administering gas anesthesia. The apparatus is equipped with two tanks—one of oxygen and the other a mixture of 90 per cent oxygen and 10 per cent carbon dioxide, so that either can be used with ease. The mechanism of the resuscitator is contained in a central cylinder and is mounted on a three-wheeled carriage. The motivating power is derived from the pressure in the oxygen tanks. The apparatus exerts a positive pressure of 13 mm. of mercury and a negative pressure of 9.75 mm. of mercury in continual alternating sequence and is controlled automatically.

The resuscitator is almost foolproof as the positive and negative pressure ceases automatically when the child breathes of its own accord and allows it to breathe the oxygen from the bag, or, if desired, it may breathe the oxygen-carbon dioxide mixture through the inhalator attachment.

Easy on the Feet

We shall gladly nominate for the hall of fame the inventor who will come forward with an auto-gyro attachment for human beings that will enable us to scoot around on our daily affairs without touching the ground. When that day comes, the discomfort of traveling over hard, unyielding surfaces will cease to worry us, but until then floors will remain a matter of paramount importance to all who do much walking. Particularly so, for persons like nurses whose life is just one long, long trail a-winding from morning till night.

The American Tile & Rubber Company of Trenton, N. J., feels that it has made a contribution toward solving the problem of foot comfort in presenting Amtico rubber flooring, which adds resiliency to its other assets. These other assets, which are calculated to arouse the interest of hospital people, are longevity in the face of the heaviest traffic, ease and economy of upkeep, sanitation and quietness. Amtico, says its manufacturer, can take plenty of punishment and bob up smiling and unmarred.

Paging New Literature

Fireman, Save Yourself — Many a little boy who dreams of being a fireman grows up to have his dream come true in a less heroic way than he imagined. Fireman he is, but not the kind who drives on the big red truck and has so much fun smashing windows with an axe. His work consists of tending a furnace, in a big hospital, perhaps, with the accompanying back-breaking labor of shoveling tons and tons of coal.

Nowadays, of course, if the superintendent can be brought to see the light, the fireman doesn't have to shovel coal. He has an automatic stoker to do it for him, which leaves time for other duties and saves wear and tear on his constitution and temper.

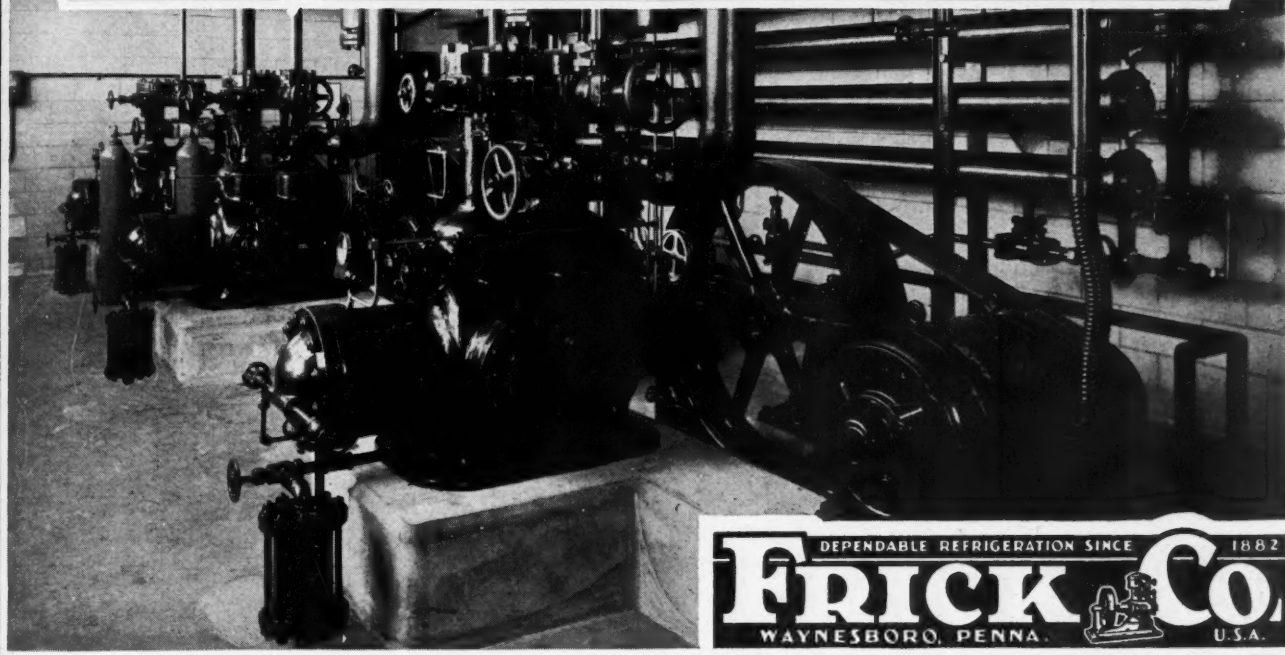
One way of selling the superintendent on the advisability of having an automatic stoker might be to let him see one of those made by the Detroit Stoker Company, Detroit. Even the casual reading of that company's most recent catalogue, describing the economy in fuel and human labor, should arouse a yen to be the proud possessor of one of these handy fellows.

From our own reading of the booklet we gather that Detroit stokers are dependable and convenient, and—a



Refrigeration

Is used to cool 166,175 cu. ft. of food storage space at the Eloise Hospital, Detroit. (Nathaniel O. Gould, Architect.) Whether you use refrigeration for cooling drinking water, conditioning air, keeping foods fresh, making ice, freezing ice cream, storing serums or any other work, you'll be safer if you specify Frick Equipment. Systems using ammonia, carbon dioxide, methyl chloride or Freon-12, to suit your exact needs.



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WRITE FOR THE FULL FACTS

big item—readily installed in all types and sizes of boilers including those already in service.

"Wild" Stream Tamed—Few things so dampen a laboratory technician's devotion as the embarrassing experience of turning on a filter pump and finding himself in a shower. And all because until recently no one was ingenious enough to produce a satisfactory de-splasher for filter pumps.

Water from filter pumps, as is well known to the trade, splashes more than it does from faucets because the pump has pulled in and entrained a considerable amount of air, which makes the stream "wild." The water tamer invented by the Fisher Scientific Company, domiciled at 711 Forbes Street, Pittsburgh, separates the air from the water and slackens the speed of flow to one-fourteenth of its original speed. The Splashgon not only eliminates the splash, but is said also to reduce by one-half the annoying sound of a filter pump in action.

It is made of a rubber exterior in the shape of a cylinder with a neck at the top that fits over the filter pump. A brass device on the interior spreads the water stream so that it flows with equal force through wire mesh at the bottom of the Splashgon.

You can read all about this and other scientific apparatus in this month's issue of "The Laboratory," house organ of Fisher Scientific.

Have a Lift—If it takes two minutes to lower a heavy load of merchandise a distance of 10 feet to a basement storage room, how long will it take to send a set of case histories from the record librarian's office to the doctor's office?

That's the kind of mathematical problem that the Sedgwick Machine Works, 150 West 15th Street, New York, delights to solve. It's all very simple, too, when you know how. The answer is that it takes two different dumbwaiters.

Sedgwick, it appears from a perusal of the latest literature, knows all the answers and is prepared to install dumbwaiters of every size, speed and capacity, from the high speed tube dumbwaiters with a capacity of 10 pounds to the ponderous "Sedg-Versal" dumbwaiter with a capacity sufficient to hoist a couple of grand pianos and Kate Smith.

A new, liberally illustrated catalogue is available at the Sedgwick offices, which gives specifications and goes into detail as to the best type of dumbwaiter for every duty. With commendable foresight, Sedgwick includes a chart of suggested uses.

On the Rebound—Bitter patients sometimes wonder why the doctor didn't send them to a boiler factory instead of a hospital: it would be less expensive and no noisier. Not only voices, but telephone bells, banging doors and clattering heels contribute to the racket, each sound traveling along in its separate sphere and each sphere clashing with a competitor, making a maelstrom of uncontrolled sound activity about the patient's bedside.

However, sound engineers have now learned how to make walls and ceilings keep quiet. Johns-Manville, 22 East 40th Street, New York City, reports that Sana-coustic Tile absorbs 85 per cent of all noise that strikes it with the result that even a perfect bedlam of noise is subdued to an undisturbing level.

Johns-Manville's new eight-page booklet on sound control tells all about the actions and reactions of noise and how best to overcome it. It also describes the J-M system of sound isolation, a process that is based on the principle of divorcing and breaking down sound vibrations at their source by making them pass in rapid succession from solid materials to soft, resilient, sound-absorbing materials.